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Policy Address^{*1}

JMAJ 51(1): 1–4, 2008

Yoshihito KARASAWA^{*2}

Recent Political Climate

It has been one-and-a-half years since the current leadership came to office, and I would like to express my heartfelt thanks for their understanding and support of the JMA's operation and various activities during this time.

Beginning with the nationwide local elections held at the start of the year, 2007 has been a year of many elections, and this year's Upper House elections were decisive in determining the direction of future public policy. This election resulted in a dramatic decrease in the number of parliamentary seats held by the ruling Liberal Democratic Party, with the opposition gaining control of the Upper House.

Over the process of several elections, the danger of collapse in regions throughout the country of community healthcare and various other systems affecting people's everyday living and livelihoods, hitherto overlooked in national policies, was highlighted; disparities between regional areas nationwide grew even greater, and the anxiety and distrust of the general public increased. The national government's hasty course of structural reform of recent years prioritizing public finance has placed tremendous strain on national healthcare and other aspects of people's everyday living and livelihoods. In the future it will be even more important to promote the formulation of policies from the perspective of the general public, providing a sense of security in everyday life, and this, as well as policy turnaround, is becoming a major proposition.

Survey of Attitudes towards the JMA

Considering this political climate, between October 2006 and March 2007 the JMA conducted a survey of more than 1,000 members of the general public on their attitudes towards the JMA in which awareness of the Association surveyed before and 6 months after the broadcast of television commercials for the JMA were compared.

The survey found that 15.6% of respondents were "interested" in JMA activities directly before the commercial broadcasts, compared with 18.9% 6 months later—an increase of more than 3 points. Similarly, the percentage of respondents who said they "held expectations" for JMA activities rose more than 3 points, from 19.3% before the broadcasts to 22.9% 6 months later. Over the 6-month television advertising campaign, interest in and expectations for JMA activities rose, if not dramatically, certainly steadily.

In contrast, JMA awareness was high (95%) both before and after the commercial broadcast, but in reality members of the general public know little about the actual activities of the JMA.

Looking at the junior high school civics textbook and the high school textbook on Modern Society, the JMA is given as an example of a lobby group. Although the expression "lobby groups" does not necessarily express a negative meaning, the JMA is an association that proactively contributes proposals for social security policies, particularly in the fields of medicine, health, and welfare, as well as collaborates with the government, strives to prevent disease, with school doctors providing support in schools and industrial doctors providing support in companies.

^{*1} This is an English version of the policy address originally delivered in Japanese by Dr. Yoshihito Karasawa at the 117th Extraordinary General Assembly of the JMA House of Delegates held in Tokyo, October 28, 2007.

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There is a need to increase the general public's awareness that the JMA is an organization that is deeply involved in healthcare-related activities in the community.

The Endangered State of the Universal Healthcare System

The Michael Moore film, "Sicko" has been recently screened in Japan. That this film portrays the plight of some 150 million Americans who have private medical insurance—and not the 45 million Americans that are uninsured—provides important talking points for discussing the direction of healthcare in Japan.

Japan's universal healthcare system is today facing a tremendous crisis, and I would like to briefly discuss below five points that have emerged as characteristics of this crisis.

Firstly, the number of medical institutions unable to provide childbirth services has increased rapidly on a nationwide basis, causing tremendous anxiety for many women. In 1996 there were 3,991 medical facilities providing birthing services, but 10 years later, in 2006, this figure had dropped some 27% to 2,933. Even amongst facilities claiming to have a "Department of Obstetrics and Gynecology," in reality there are now some that only provide gynecology services.

Behind this drop is not only the decrease in obstetricians due to harsh working conditions but also the increase in cases of criminal action being taken against doctors when accidents have occurred during childbirth. Consequently, the number of hospitals that do not provide childbirth services has increased and the number of medical interns desiring to become obstetricians has decreased dramatically.

As part of the JMA's response to this problem, we proposed the establishment of a system of a no-fault compensation system which looks likely to be realized. Under this system, we hope to propel medicine towards a situation where women can give birth with peace of mind.

Secondly, there is a dearth of pediatricians in emergency pediatric care. More than half of the patients who are seen at emergency medical centers at night or on weekends are children. With the extreme shortage of hospital pediatricians, the situation arises in which a doctor goes on night duty after working a full day of routine duties, deals with the nighttime emergency cases,

then goes straight back to their daytime duties without catching one wink of sleep. Such cases are by no means rare. This situation has led to hospitals throughout the country closing their pediatrics department. In 1996, 35.2% of hospitals had pediatrics departments, but by 2006 this figure had dropped some 6 points to 29.2%. Normally this would be a problem for the national government and local government bodies to resolve, but local medical associations are in some areas taking a central role in proactively providing emergency pediatric services by sharing the nighttime work during a certain timeframe amongst local medical institutions and doctors. The extremely harsh working conditions for hospital pediatricians is unimaginable, and the JMA has marked it as an urgent issue which we will work to resolve through further cooperation with local medical associations.

Thirdly, there is concern about people dying solitary deaths. Japanese society has aged very rapidly over the past several years and the number of households exclusively comprising old old people is increasing. In 2005, 33.2% of old old people—one in three—lived in households comprising only elderly people, and consequently solitary deaths are becoming a huge social problem. Under such circumstances, the Ministry of Health, Labour and Welfare plans, in the name of "Reorganization of Long Stay Beds," to reduce the number of hospital beds from the current 380,000 beds to 150,000 by 2012, the reason given being to prevent "social hospitalization" by elderly people.

However, surveys conducted by the JMA of the conditions for hospitalized patients found that there was also significant numbers of gastric tubal feeding and sputum aspiration patients; objectively considering the situations of patients who, in addition to whole-body management, must be hospitalized in order to adequately care for, some 250,000 long-stay beds will be still be required in 2012. The expulsion of such patients from hospitals would create a massive number of "medical refugees" and "nursing care refugees."

The JMA is firmly opposed to the widespread reduction of long-stay beds. In order to avoid any sudden changes, regardless of whether the patient is being treated at home or in a medical facility, changes must be considered gradually, beginning with the making of thorough preparations. Moreover, patients hospitalized and in hospital beds

would not necessarily prefer to be treated and cared for in their own home.

Fourthly, there is the issue of healthcare expenditure standards in Japan. The World Health Organization (WHO) has ranked Japan's healthcare achievement as the highest in the world. However, Japan's healthcare expenditure/GDP ratio was ranked 22nd amongst the 30 developed nations who are members of the Organisation for Economic Co-operation and Development (OECD) according to 2004 figures. The average ratio for the 30 developed countries was 8.9%, with a ratio of 8.0% for Japan. That one of the world's economic powers has such extremely low healthcare expenditure compared with other countries is demonstrated by these official figures.

Fifthly, there is an absolute dearth of doctors in Japan. Looking at the number of doctors in Japan per 1,000 head of population, the average for OECD member countries is 3.1 whereas for Japan it is 2.0. The same figure for France is 3.4, for Germany 3.4, and for the United States 2.4, placing Japan in last place amongst the group of member countries with per capita GDPs above the OECD average. In addition to the overall dearth of doctors, there are severe disparities between cities and regional areas. The reason for this is the weakening of the doctor dispatch function of university hospital departments stemming from the introduction of the new doctor clinical training system which began in April 2004. Demand for doctors far exceeds supply, and consequently interns are concentrated in city hospitals with good facilities and training programs or hospitals that pay high wages, even if temporarily.

Japan's healthcare achievement is the highest in the world in part because of the high diligence and health awareness of the general public, but the fact that the healthcare system is supported by the self-sacrificing care provided by doctors, nurses, and other healthcare professionals should be re-acknowledged and appreciated.

Finance-led Healthcare Expenditure Restraint Policies

“Healthcare collapse” is fundamentally the result of the national government's healthcare expenditure restraint policies and began after the

collapse of Japan's bubble economy. However, the problem became most pronounced from the time of the Koizumi Administration's “structural reform with nothing sacred” policy, which took a large axe to social security areas.

Over the past 5 years, between 2001 and 2006, in contrast to the natural increase of necessary social security expenditure (paid by the government), some 3.3 trillion yen (28.7 US dollars)*³ in national treasury payments was lost. The natural increase in healthcare expenditure—said to be 2–3% annually—is the increase in expenditure due to advances in medicine and healthcare. In fact, 70% of the vanished 3.3 trillion yen of social security expenditure has been achieved by the curbing of healthcare and nursing care expenditure to the point where has become difficult to provide “costs for safety,” let alone “costs for peace of mind.” As if to demonstrate this, medical institutions have been going bankrupt at the worst pace ever this year. If this restraint on healthcare expenditure continues for another 5 years, 12 trillion yen (104 billion US dollars) in national treasury payments will be cut from social security expenditure, bringing the total loss of healthcare expenditure to approximately 8 trillion yen (69.6 billion US dollars).

Curbing of healthcare expenditure is aimed at curbing benefit expenditure, and is thrown back at the general public in the form of increases in patient charges. Moreover, ensuring the supply of doctors, nurses, and other medical professionals will become difficult, leading to excessive overwork and the reduction of time for each patient to be treated individually, all of which would be highly detrimental to the general public.

Amongst members of committees such as the Council on Economic and Fiscal Policy and the Council for the Promotion of Regulatory Reform are some who are considering introducing insurance exemptions and mixture of public insurance and private payment in order to reduce the burden on the national government. However, this would make it very difficult to maintain the equity of healthcare in Japan.

We do not advocate that medical expenditure should match that of the United States but instead propose that a healthcare expenditure scale commensurate with national and economic power be achieved and that regional systems for providing

*3 1 US dollar = 115 yen.

healthcare be enhanced. This would be a first step towards enabling those people whose efforts contributed to Japan's economic growth and those who have health anxieties and their families to live their lives with peace of mind.

Government in Japan in recent years has seemed to focus entirely on economic and fiscal management and, cursed by an ever-increasing government bonds outstanding, has been preoccupied solely with fiscal revenue and expenditure.

Maintaining Steady Regional Healthcare Systems

The nation's greatest assets are its people. The first responsibility of the national government is to secure the country and the lives and property of its citizens, protecting the everyday lives of the people, and maintaining a society that enables the people to live enriched lives and local communities that are safe and enable trust. The key to this is the construction of a rich lifestyle foundation that looks ahead and that focuses on the smallest structural units of society—the household and the family.

Unless the national wealth contributes adequately and effectively to the welfare of the people, it would be completely impossible to construct the basis for a 100 year of the nation.

As society ages and the birth rate decreases, we must avoid increasing the burden on regions, exacerbating disparities between regions, and spreading anxiety.

Now is precisely the time we need to reaffirm the section of Article 25 of the Japanese Constitution that sets out the right to life and security of the people and the nation's social mission. Now is the time to explain to and gain the understanding of the general public regarding the difficulty now being faced in maintaining regional healthcare systems for the safety and security of that region, as well as the fact that this is an important period for formulating policies that maintain and strengthen the universal healthcare system.

Following the publication of our "Grand Design 2007—General Outline—," the JMA has published "Grand Design 2007—Specific Views—" as its sequel. The JMA aims to further strengthen the universal healthcare system so that members of the general public are universally able to receive good quality and highly satisfactory healthcare. To achieve this, from the standpoint of protecting the lives and health of the people, we will proactively make proposals to the government from the same perspective as members of the general public, while promptly and proactively working to resolve issues that the Association should respond to.

School Health Activities in Japan

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Abstract

The Japanese school health system can be traced back to the promulgation of the school system in 1872, when its major aim was to implement measures to prevent schools from serving as a medium for the transmission of prevalent infectious diseases such as smallpox and cholera. In 1898, an imperial ordinance was issued to place school doctors in public schools. Since then, school doctors have played a central role in school healthcare. In more recent years, we have seen rapid changes in social and living environments, and these changes have been accompanied by a wide spectrum of new health issues including mental health problems and the onset of lifestyle-related diseases at younger ages. The cooperation of specialists from a variety of medical fields as well as health education and health management that provides a firm basis for lifelong health in schoolchildren are necessary and will become an integral part of the role assigned to school doctors in the future.

To deal with such a wide variety of issues, the JMA has introduced a three-pillar policy, i.e., the JMA School Health Committee, school doctor training sessions, and national conventions of school health providers and school doctors. Currently, the JMA is working with the national government and other relevant organizations on various approaches, holding training sessions which are intended to spread of the knowledge required by school doctors. In order to make good use of the know-how regarding school health activities in Japan and to improve the level of health in developing countries, a joint international project was implemented in Nepal and has produced excellent results. It is hoped that Japan will make greater contributions to global health through efforts such as these.

Key words School health, School doctor, School Health Law, Health education, Global health

Introduction

The Japanese school health system was established at about the same time as the modern Japanese educational system and thus has a history of more than a century. In the middle of the 19th century (1866), Dr. Hermann Cohn, professor of Ophthalmology at the University of Breslau, Germany, proposed allocating doctors to schools to provide inspection and guidance in the hygienic and environmental conditions of the school, since the incidence of myopia was particularly high among school attendees. Consequently, the need for management and guidance of hygiene in schools was advocated in Europe at the time. Following the European lead, Japan formulated a system to manage the health of children in school and to facilitate their growth and development.

Before the end of World War II, the system was called the school hygiene system, but it was later known as the school health system. There was also a transition in the activities required to maintain school health from the periods of Meiji (1868–1912) to Taisho (1912–1926), Showa (1926–1989), and Heisei (1989–).

This paper outlines the background and process of establishment of the school health system in Japan, discusses new issues of school health currently occurring in the school system, and introduces activities being carried out by JMA to solve such issues.

The School System and the School Doctor System in Japan

An outline of the current Japanese school system will be given below because it is necessary to

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understand the system that underlies school health in Japan.

The current Japanese school system has been in place since 1947, when the School Education Law was enacted. The current system is a 6-3-3-4 system that comprises 6 years of elementary school, 3 years of junior high school, 3 years of senior high school, and 4 years of university. This system is a consistent single-track system that basically offers the same curriculum to every child. The education of children is classified as preschool, primary/secondary, and higher education.

Preschool education is provided to children prior to school age at child-care centers or kindergartens, although attendance at such facilities is not obligatory. Primary and secondary education are compulsory in Japan. Children who are 6 years old as of April 1 enter an elementary school as first graders who then receive 9 years of education in an elementary school (6 years) and a junior high school (3 years). The school year begins in April and consists of 3 terms, each followed by a break in summer, winter, and spring, respectively. Under the current system of compulsory education in elementary and junior high schools, tuition and textbooks in public elementary and junior high schools are free of charge. Those who have completed the 9 years of compulsory education and have passed the entrance examination can enter a senior high school. Senior high schools provide 3-year courses designed for general education, technical education, or a combination of general and technical education. After senior high school, students can go on to higher education, primarily in universities or junior colleges. These organizations provide higher and more specialized education. The term is 4 years in universities and 2 years in junior colleges. Beyond these schools, graduate schools are available (2 years for a master's course and 3 years for a doctoral course).

School health is defined as "health education and health management in school" in No. 12, Article 4 of the Establishment Law of the Ministry of Education, Culture, Sports, Science and Technology (MEXT). In addition, in Article 1, Chapter 1 of the School Health Law, the purpose of formulating the School Health Law is specified as follows: to prescribe necessary matters relating to health and safety management in school, to promote maintenance and enhancement of the health of schoolchildren and students, as well

as infants and school personnel, and to thereby facilitate smooth implementation of school education and securement of its achievements. Article 16 of this law regulates that schools shall have school doctors, providing a legal basis for their presence. "School" here is any of the schools prescribed in Article 1 of the School Education Law, i.e., elementary, junior high, senior high, and secondary schools; universities; specialized vocational high schools; schools for the blind, deaf, and handicapped; and kindergartens. In principle, school doctors are present at any stage of education under the school system in Japan. According to the School Basic Survey (fiscal 2006) conducted by MEXT, there are 22,878 elementary schools (including public and private) in Japan, and 22,420 (98%) of them have school doctors. A total of 59,006 doctors are serving as school doctors for elementary schools, accounting for 2.6 doctors per school. Results of statistics are similar for junior high and senior high schools. Thus, it is apparent that the school doctor system is functioning as a nationwide system.

The board of education of each local government is responsible for implementing school health administration in public schools. Among private schools, the section governing private schools in the clerical department of the prefectural government is responsible. The status of the school doctor in a public school corresponds to that of part-time school personnel. In most cases, local medical association members perform the activities of school doctors as part of community medicine.

Developmental History of the School Health System

Development in the pre-war period

As was mentioned at the beginning, the Japanese school health system has a long history that can be traced back to the promulgation of the school system in 1872, the fifth year of the Meiji period (1868–1912), with the major aim of taking measures to prevent schools from serving as a means of transmission of prevalent infectious diseases such as smallpox and cholera.

The initial measure related to school environmental health in the school health system was the allocation of a contract investigator of school hygiene issues, Michiyoshi Mishima, of the Ministry of Education in 1891. Mishima conducted an

Table 1 Role of school doctors as prescribed by the school doctor's job regulations (1898)

1. Quality of air ventilation
2. Adequacy of lighting
3. Adequacy of desk and chair
4. Distance from the chalk board to the front row and to the backmost row
5. Presence/absence of fireplace, and distance between the fireplace and the nearest seat
6. Room temperature
7. Hygienic adequacy of books, wall charts, and chalk boards
8. Status of school cleaning procedures
9. Adequacy of water for medical use and issues related to environmental hygiene

investigation of the situation of school hygiene in various parts of the country, and the results of the investigation were reflected in various policies regarding school hygiene. School doctors were first adopted as contractual doctors in the Kojimachi area of Tokyo in 1894. In 1896, the Ministry of Education set up a school hygiene advisory committee to develop the school hygiene system, choosing the school doctor system as the subject of discussion. In 1898, an imperial ordinance was issued to place school doctors in public schools. At that time, "school doctor's job regulations" were issued to officially stipulate the position of school doctor. This allocation of school doctors to public schools throughout the country was the first such case in the world. The duties of school doctors at that time included inspection of classes at least once per month, observing for nine hygiene items (Table 1), and offering outside advice as a supervisor. In addition, school doctors were in charge of physical examinations as specified by the "schoolchildren and students physical examination rules," which prescribed that the physical examination of children be performed in April and October every year and include 11 items: height, weight, chest circumference, spinal column, physique, visual acuity, eye disease, hearing acuity, ear disease, teeth, and other diseases. The provision of therapy was not included in the duties of school doctors.

However, in the Taisho period (1912–1926), the school environment itself was improved, and the rate of enrollment of school-age children

increased, resulting in attendance by more children with diseases and physically weak children, thereby increasing the need for management of schoolchildren's health. In addition to the more passive measures, it was considered necessary to take measures aimed at the maintenance and enhancement of health, including improvements in nutrition, physical training, fragile habitus, etc. As a result, the school doctor's job regulations were amended in 1920. The amendment stipulated matters related to the supervision and care of sick, weak, or mentally retarded children, thereby expanding the conventional duties concerning environmental hygiene and physical examination. For example, school doctors were required to advise in matters of school attendance by affected children and provide guidance as to how to deal with such children. Since this new role was imposed on school doctors, additional staff members were required to serve as assistants of school doctors in the schools and to play a major part in the practical work of supervising and caring for children, and, consequently, the number of school nurses increased dramatically. School nurses were adopted first in Gifu Prefecture in the main island of Japan in 1905. They were placed initially to carry out eye washing procedures to cope with the concern existing at that time. In the late 1890s to early 1990s, there were major epidemics of trachoma in Japan causing many pupils and students to be absent from school for long periods of time, creating a problem from the educational standpoint.

In the Showa period (1926–1989), tuberculosis became a national affliction and was regarded as a serious social problem, and the need for prevention in the adolescent stage was advocated. As a result, special classes for the care of physically weak or scrofulous children were formed in various schools around the country. To screen for tuberculosis, intracutaneous tuberculin testing, roentgenography, and bacteriologic examination were performed for schoolchildren, and care classes were formed for tuberculin-positive children and those with suspected tuberculosis, to provide extensive health guidance.

As wartime approached, improvement of the health status and strength of schoolchildren was regarded as an important theme and attracted a great deal of attention. The priority of the school health policies rapidly changed from the former therapeutic measures to preventive medicine and

Table 2 Duties of school doctors as prescribed by Article 23 of the Enforcement Regulations of the School Health Law (1958)

1. Participating in school health planning
2. Providing necessary guidance and advice in cooperation with school pharmacists in the maintenance and improvement of school environmental hygiene
3. Being engaged in the health checks of schoolchildren, students, and infants
4. Being engaged in the preventive treatment of diseases and in health guidance
5. Being engaged in health counseling
6. Providing necessary guidance and advice as to the prevention of contagious diseases, and providing preventive treatment of contagious diseases and food poisoning in schools
7. Providing first-aid treatment by request from the principal
8. Being engaged in health examinations of children ready for school and school personnel as requested by municipal education boards or the school founder
9. Providing guidance about professional issues concerning health management in schools as needed

training.

The major role of school doctors in the Meiji period was the management and guidance of school environmental hygiene. From the Taisho to early Showa period, school doctors played a central role in healthcare at school. At any rate, it is clear that school doctors played a central role in school health (hygiene) from the Meiji period to the prewar period.

Development in the post-war period

After the war, the school doctor system was legislated by the School Health Law, established in 1958. Although the Basic Education Law and the School Education Law were promulgated in 1947, after the war, there were no regulations regarding school doctors until the establishment of the School Health Law. Article 16 of the School Health Law prescribes that schools shall have school doctors, and that school doctors be engaged in technical and guidance activities in relation to specialized issues of health management. According to Article 23 of the Enforcement Regulations of the School Health Law, the duties of a school doctor are classified into 9 categories (Table 2).

As prescribed in Article 2 of the Enforcement Order of the School Health Law, children ready for school receive a health examination consisting of the following items: 1) nutritional status, 2) presence/absence of disease and abnormality of the spinal column and thorax, 3) visual and hearing acuity, 4) presence/absence of disease and abnormality of the eye, 5) presence/absence of otorhinopharyngeal disease and skin disease, 6) presence/absence of dental and oral disease and abnormality, 7) presence/absence of other disease and abnormality. From this, it would seem natural that three doctors, i.e., an internist (or pediatrician), ophthalmologist, and otorhinolaryngologist, would be in charge of a school. However, as mentioned previously, there are no legal regulations as to the specialties of school doctors.

Major health issues found in schoolchildren at the time the School Health Law was established included parasitic infection, trachoma, tuberculosis or other infectious diseases, and decayed teeth. In coping with these issues, school health activities achieved significant results through health screenings based on the School Health Law. However, in more recent years, we have seen rapid changes in social and living environments due to urbanization, declining birthrate, an increasing proportion of the elderly, informatization, and internationalization. These changes have been accompanied by a wide spectrum of new health issues including bullying, school avoidance, allergic diseases, problematic sexual behavior and drug abuse, emerging or reemerging infectious diseases, diseases and disorders of the motor apparatus due to excessive exercise and sports, onset of lifestyle-related diseases at younger ages, and so on. Thus, the field of school health is in need of new strategies.

School Health Measures Related to the Activities of the Japan Medical Association (JMA)

The mission of the JMA aims at the enhancement of medical ethics, advancement of medical education, overall progress of medicine and related sciences, continuing education, and other activities. Major activities of this organization include medical policy decisions, dealing with various bioethical issues, scholarly activities, promotion of medical services, healthcare and welfare, promotion of international cooperation, and public

Table 3 Matters under deliberation in the School Health Committee of the Japan Medical Association during the past decade

1. School doctor as it ought to be in the new century (July 1998)
2. The modality of health education and measures for its promotion in the activities of school doctors (July 2000)
3. Practice of school doctor activities and means of its expansion (July 2002)
4. Practice of health education by school doctors (September 2004)
5. Lifetime health and school health (September 2006)

relations. School health activities are categorized under the promotion of medical services, health-care, and welfare.

To promote school health activities, the JMA has introduced a three-pillar policy, i.e., the school health committee, school doctor training sessions, and national conventions of school health providers and school doctors.

The school health committee consists of local medical association board members in charge of school health (representatives of respective blocks), representatives of various medical fields (internal medicine, ophthalmology, otorhinolaryngology, psychiatry, obstetrics and gynecology, orthopedics, dermatology), representatives of the Japanese Society of School Health, and academic experts on particular learning and experience in school health (particularly matters of school doctors). This committee discusses problems on the basis of an understanding of the current status of school health, proposals or suggestions for solutions to problems, school doctor training sessions (described below), planning and operation of national conventions of school health providers and school doctors, and issuance of reports to biennial inquiries from the president of the JMA concerning future perspectives and other issues of school health (Table 3). In response to recent reports, the JMA set up the following targets: 1) shifting from health management by school health screening toward health education, 2) having a school health committee at every school, 3) implementing health education through health counseling, 4) ensuring the participation of various specialists (particularly from psychiatry, obstetrics and gynecology, orthopedics, and dermatology)

as school doctors in addition to the more common internists, ophthalmologists, and otorhinolaryngologists. Currently, the JMA is working with the national government and other relevant organizations in various approaches to fulfill these targets.

School doctor training sessions are held annually by the JMA, and, with support from the Japanese Society of School Health, with the aim of improving the quality of school doctors. Training sessions are intended for the spread of knowledge necessary for school doctors in pursuing their duties and provide opportunities to discuss various issues and formulate new measures and policies. In addition, the JMA issued "A Guide for School Doctors" in 2004 to make school doctor activities more effective in practice and to further enrich them.

National congresses relating to school health and attended by school doctors are held by the JMA. As a place for study that includes discussions by school doctors on a national scale, the congresses have been held in various parts of Japan since the first congress in Akita Prefecture in 1970, in cooperation with the regional medical association in charge.

In order to make good use of the know-how regarding school health activities in Japan and to improve the level of health in developing countries, a project in international cooperation, the "JMA School and Community Health Project," was begun in 1992 in Nepal, one of the developing countries, and has continued for 12 years. The project was adopted as the prototype of the current pediatric health policy in Nepal, and has earned a decoration conferred by the king of Nepal as the result of its valuable achievements.

Current Problems and Future Perspectives in School Health

As mentioned previously, because of rapid changes in society and lifestyle, Japanese schoolchildren have a wide spectrum of new health issues including mental health matters such as bullying and school avoidance, allergic disease, problematic sexual behavior and drug abuse, emerging or reemerging infectious diseases, diseases and disorders of the motor apparatus due to excessive exercise and sports, young age of onset of lifestyle-related diseases, and so on. Thus, the field of school health is in need of new

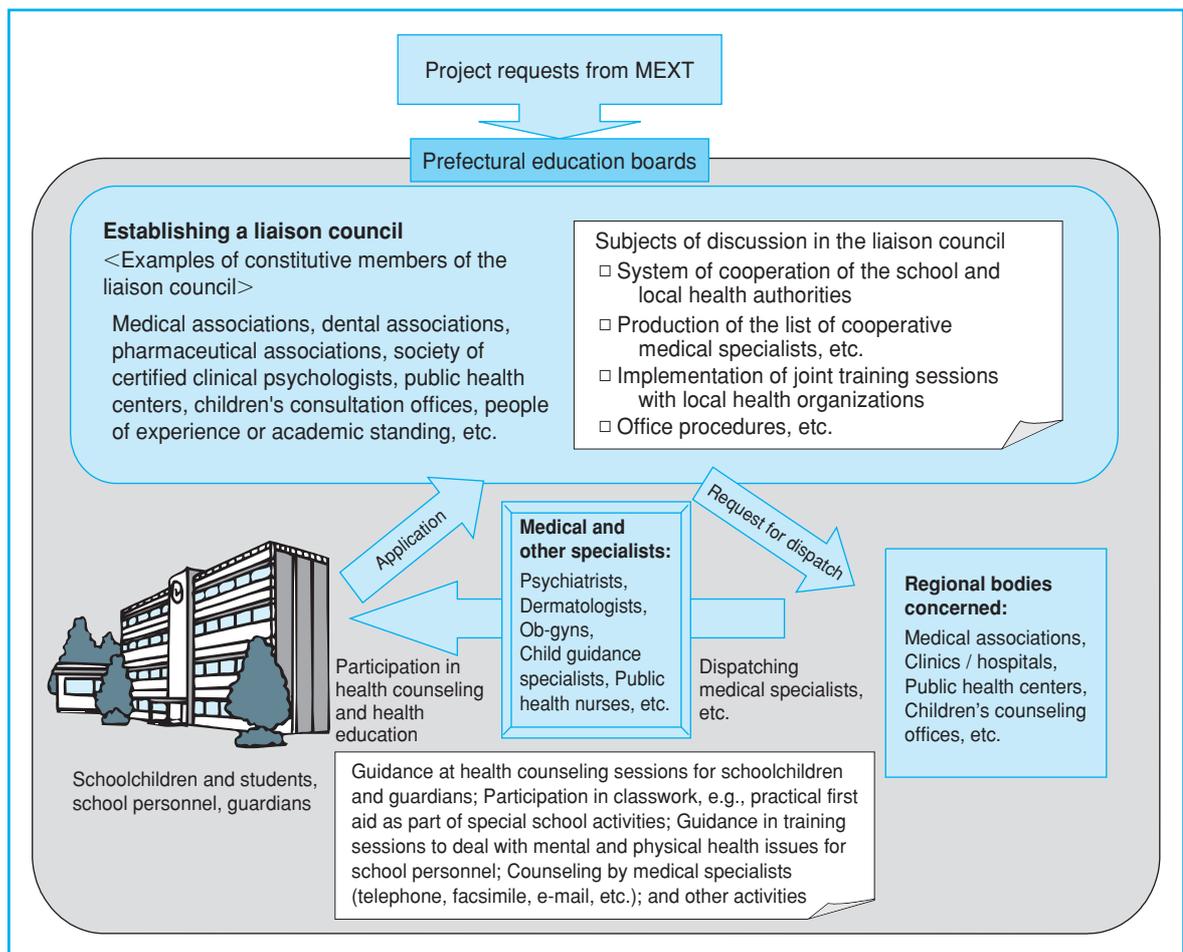


Fig. 1 School regional health cooperation project (launched in 2004)

strategies. JMA considers the school doctor system comprising the three major specialties of internal medicine, ophthalmology, and otorhinolaryngology no longer suitable for dealing with such a wide variety of issues, and has indicated the need for specialists from psychiatry, obstetrics and gynecology, orthopedics, and dermatology to attend to the aforementioned issues and to participate in school health activities as school doctors.

Since 2002, the JMA, particularly the School Health Committee, has discussed the issues of cooperation and support of doctors from various specialties, and a JMA model project—the practice research project on school health activities by doctors of various specialties—was conducted in Chiba, Kanagawa, and Osaka Prefectures in 2003 and 2004. This project was further extended

to Hokkaido, Mie, and Okinawa Prefectures the following year. Based on the results of this project, the JMA requested MEXT to expand it to a nationwide model project. As a result, the school regional health cooperation project (Fig. 1) was launched by the Japanese government in 2004 as a national program to cover all 47 prefectures. Through this program, specialists of psychiatry, obstetrics and gynecology, orthopedics, dermatology, and other medical fields are sent to individual schools to provide health counseling, educational training programs for parents and school personnel, and other services. Recognizing the importance of this program, the JMA has suggested to MEXT on all possible occasions that the program be perpetuated and expanded. As a result, a more extensive cooperative regional program for protecting children's health has

expanded to a total of 111 areas, comprising 2 areas each of 47 prefectures and 1 area each of 17 government-decreed cities was included in the estimate of national budget requests for fiscal 2008. To achieve smooth operation of this program in various parts of the country in the future, the following will be needed: various efforts including reinforced cooperation of local medical associations and boards of education, development of health education materials and application of information technology by the JMA and prefectural medical associations, and creating teams of specialists on a regional basis through the cooperation of specialists from a variety of medical fields. The JMA has high expectations that the various issues emerging in school health in Japan will lead to solutions through these active efforts.

On the other hand, the probability of death from any of the three major causes—malignant neoplasm, cardiac disease, and cerebrovascular disease—exceeds 50% in Japan for both males and females of any age. One-third of national health-care expenditures are used for the treatment of these lifestyle-related diseases. Considering the enormous economic loss from lifestyle-related diseases in individuals and society, rapid and radical actions are called for. Measures of secondary prevention alone, such as early detection by health screenings and early treatment, are not sufficient to deal with these problems adequately. Thus, increasing importance is being placed on primary prevention centering on lifestyle modification. As a practical strategy, it is important that children learn and practice proper eating habits, engage in physical activity, and establish good sleep habits in order to have a well-balanced lifestyle that leads to the prevention of lifestyle-related diseases. It seems that

health education and health management will provide a firm basis of lifelong health in school-children and will become an integral part of the role assigned to school doctors in the future.

Concluding Remarks

As described above, one of the foundations of national public health has been the establishment of school health in Japan. These efforts have led to today's high health standards and long-living society, results which the JMA has made significant contributions to attain. Sharing its long experience in the school health area, the JMA also launched a school/community health project in Nepal and achieved great success in decreasing the mortality of children. Recognizing the achievements of the JMA's activities in Nepal, the Nepalese government established a concept of "School Health" to be jointly supported by the Ministries of Health and Education. This is the starting point for increasing health standards in that country. The development and improvement of school health in developing countries would produce great benefits of the people of these countries.

The JMA intends to do its best not only to improve the quality of school health in Japan, but also to make substantial contributions to the promotion of global health activities. As a long-standing member of the World Medical Association (WMA) and one of the founders of the Confederation of Medical Associations of Asia and Oceania (CMAAO), the JMA has a high responsibility to make efforts in this area. It is our hope that the experience of Japan and the JMA described in this article will provide suggestions for the efficient development of school health activities in other nations.



The 25th CMAAO Congress and the 43rd Council Meeting: COUNTRY REPORTS

Hotel Royal Cliff Beach and Resort, Pattaya, Thailand
November 18–20, 2007

The 25th CMAAO (Confederation of Medical Associations in Asia and Oceania) Congress and the 43rd Council Meeting was held from November 18 (Sun.) to 20 (Tue.), 2007, in Thailand. This issue of the JMAJ features the country reports of seven NMAs presented during the Country Report session on November 19 in which each member NMA reported its major activities over the past year.

This year's congress was attended by some 50 representatives of 13 member NMAs. With the re-admittance of the Sri Lanka Medical Association officially decided, CMAAO now has a membership of 17 medical associations. CMAAO was founded in 1965 with a membership of 10 medical associations, but substantive activity began at the 1st CMAAO Congress held in Tokyo, Japan, in 1959. For this reason, this year's congress considered plans for events celebrating the confederation's 50th anniversary in 2008/2009 as well as invigoration of confederation activities.

Decisions made concerning CMAAO operations included newly appointing a legal advisor to provide support for legal aspects of future confederation activities; revising the Constitution and Bylaws to renew and strengthen organization; and making efforts to recruit those NMAs that are members of MASEAN (Medical Association of South East Asian Nations) but not yet of CMAAO.

At the Opening Ceremony held on November 19, Professor Dr. Somsri Pausawasdi (Immediate Past President, The Medical Association of Thailand) was installed as the 28th President of the CMAAO (term: 2 years; 2007–2009) and presented with the CMAAO Presidential Medal by out-going President Dr. Jae Jung Kim of Korean Medical Association.

The symposium held on November 20 on the theme "Arts and Science of Healthy Longevity" will be featured in the JMAJ 51(2).



Handover of a Presidential Medal

HONG KONG MEDICAL ASSOCIATION

CHAN Yee-shing Alvin*¹



REPORT ~ THE HONG KONG MEDICAL ASSOCIATION

For Year 2006-2007

Protest against Link Real Estate Investment Trust (Link REIT)

- Unscrupulous rental increase in public housing estates
- Press conference on 3 December 2006
- Rally and march on 14 December 2006



*1 Council Member, Hong Kong Medical Association, Hong Kong (yvonne@hkma.org).

HA Junior doctors Sit-in (I)

- Fight for equal pay
- Staff exodus
- Pay-rise
- Increase in intake of medical students
- Supporting their sit-in on 23 June 2007



HA Junior doctors Sit-in (II)

- Supporting their protest march on 30 June 2007
- Recent resolution

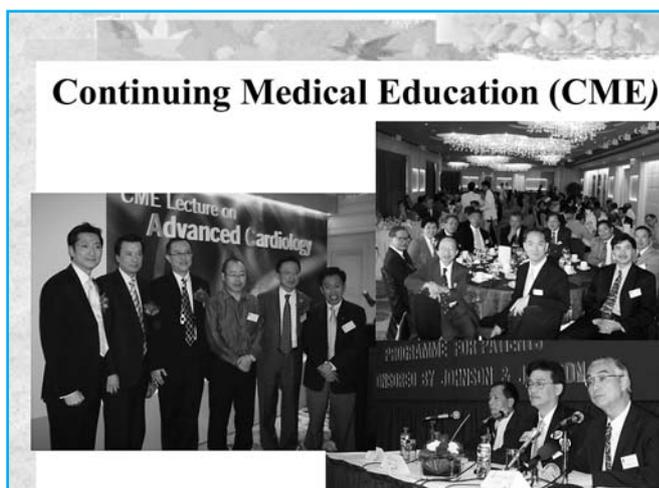


Medical Students Intake Increase

- Meeting with Secretary for Education in August 2007
- Secretary promised to look into the matter from the perspective of overall supply and demand of medical manpower

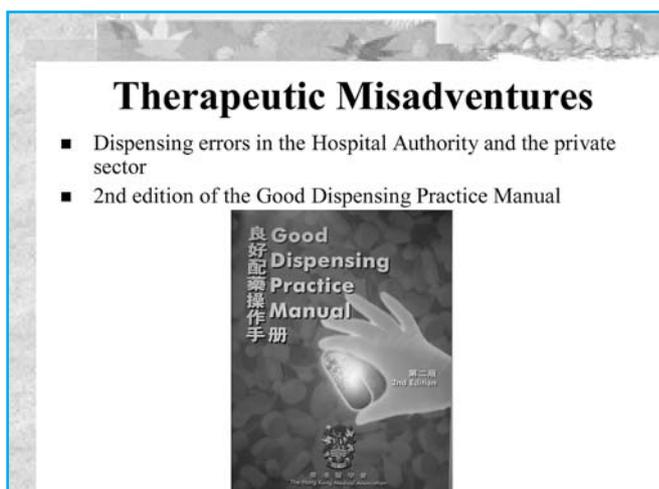
Victory with 50% of seats in Election Committee Medical Subsector Election

- HKSAR Legislative Council Medical Subsector Election - December 2006
- Prepared for HKSAR Chief Executive Election March 2007
- Forums



Fight :
against allowing parties with vested
interests to make CME linked to
registration/annual practising
certificate

- Medical Council of HK (MCHK)'s unilateral decision and actions
- HKMA's actions



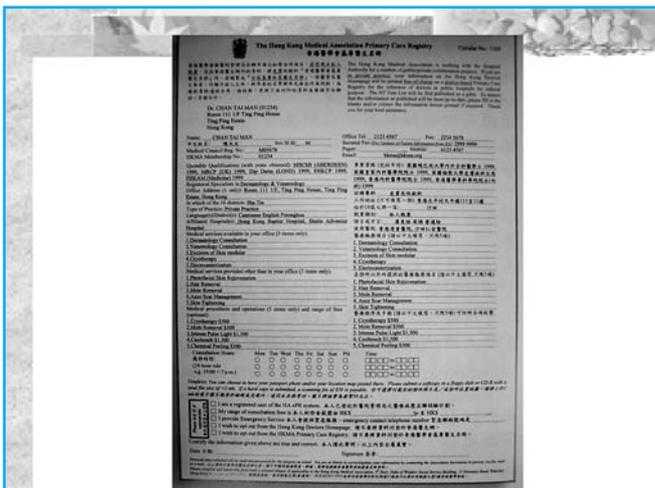
Beijing/Hong Kong Medical Exchange

- Co-organized with Chinese Medical Association
- November 2006
- Theme: Community Health Service & Family Medicine



Primary Care Registry

- Public-private collaboration
- Family doctor concept
- New Territories East as pilot
- November 2006
- Challenged by Medical Council of Hong Kong
- Resolution



Separation of Dispensing from Consultation

- Public opinion poll in late 2006/early 2007
- Conducted by Public Opinion Programme, The University of Hong Kong
- Result: 3/4 respondents objected to separation of dispensing and prescription

Dangerous Drugs Register

- Kept in electronic form?
- HKMA vs. Hong Kong College of Family Physicians
- Resolution

Health Maintenance Organizations (HMOs) and Medical Insurance

- Professional autonomy
- Customer service
- Patient care and choice
- to work on core elements of good medical insurance scheme

Healthcare Financing

- Bauhinia Report – June 2007
- Press Conference on 24 July 2007
- HKMA Stand:
 - Pillar 1 vs. Pillar 2
 - Health and Medical Development Advisory Committee (HMDAC) report on public subsidized services
 - Contribution vs. savings
 - “money to follow the patient” rule

Cultural & Sports Activities

- HKMA Charitable Foundation
- HKMA Orchestra
- HKMA Choir
- HKMA No.1 Band
- Organ Donation Register
- Sports
 1. Family hiking
 2. Joint Professional Tournaments in Badminton, Basketball, Table-tennis and Golf
 3. Sports Night



General

- Council Meetings
- 42nd CMAAO Council Meeting held at Singapore in November 2006
- 57th World Medical Assembly held in Sun City, South Africa, in October 2006
- The Eighth Beijing and Hong Kong Medical Exchange Meeting focusing on “Community Health Services and Family Medicine ” was successfully held in Hong Kong last year
- 12 monthly HKMA News
- 12 monthly CME Bulletins
- bimonthly Hong Kong Medical Journal

Surveys

- drug dispensing
- judicial review
- MCHK composition
- LINK Management
- Primary Care Registry
- Visiting Medical Practitioners Scheme
- the new CME Online website and bulletin

Representation of HKMA in the Statutory Governing Body of MCHK

- 7 elected representatives
- also representatives in:
 1. Ethics Committee
 2. Education & Accreditation Committee
 3. Health Committee
 4. Licentiate Committee
 5. Credentials Sub-Committee of the Licentiate Committee
 6. Exemption Sub-Committee of the Licentiate Committee
 7. Review Sub-Committee of the Licentiate Committee
 8. Preliminary Investigation Committee

END

~ Thank You! ~

INDONESIAN MEDICAL ASSOCIATION



Ihsan OETAMA*1



Indonesia Medical Association activity

National

- ❑ The 26th General Assembly, held in Semarang on Nov.29-Dec.2, 2006. Dr. Fachmi Idris was installed as the president of the Indonesian Medical Association for the period 2006-2009, and Dr. Prijo Sidipratomo as vice-president/president -elect.
- ❑ Opening Ceremony was conducted at Presidential Palace
- ❑ Dr. Datuk Arumugam, President of WMA was invited to speak on this occasion.



Indonesia Medical Association activity

National

- ❑ January 2007 : Plenary session of the IMA, followed by a workshop to compose the IMA's grand strategy , that is :
 - ❑ a. Vision :Producing Indonesian doctors with global competency with a high regard for humanity values.
 - ❑ b. Mission : To enhance the dignity and well being of a doctor in creating a healthy society..
- ❑ IMA's Grand Strategy :
 - To strengthen organisational infrastructure (central, regional, branch)
 - To promote the competency and ethics of a doctor in Indonesia, according to the competency and ethical standards of Indonesian medical system.
 - Creating an integrated medical service system.
 - Formulating an IMA image as an active medical profession organisation in health issues.
 - Have a good working relations regionally and internationally.
 - Members welfare.

*1 Chairman, International Relations, Indonesian Medical Association, Jakarta, Indonesia (pbidi@idola.net.id).



IMA Executive Board reported and discussed with President of Indonesia After General Assembly



IMA Executive Board reported and discussed with Vice President of Indonesia After General Assembly

Indonesia Medical Association activity

National

- February 2007 : The IMA is active in helping the victims of the five-yearly big flood that hit Jakarta, by providing clean water needed, working together with the Bandung Technology Institute.

□



- May 2007 : Present at the Constitutional Court in a Yudicial Review session for the Law of Medical Practice, in which some of the articles are not beneficial for practicing doctors

□

- June 2007 : Signing of an MoU between IMA and Indonesian Pharmacy Organisation about Medicine Promotion Ethics, witnessed by the Minister of Health, and the chairman of the Indonesian Medical Council

□

- June 2007 : Conducting the medical Check up for governor candidates in the Jakarta Election .

Indonesia Medical Association activity

National

- August 2007 : Workshop to formulate the idea of forming a General Practitioner Society, regarding the Law of Medical Practice that is not beneficial to general practitioners.
- October 2007 : Attending the WMA General Assembly in Copenhagen



Indonesia Medical Association activity

National

- October 25, 2007: the 57th Anniversary of the Indonesian Medical Association. Launching of Doctor for the Nation Program, followed by a seminar about the Indonesian Medical History, and Medical Education to face the Globalization Era.



Minister of State Secretary: Give an speech in Doctor for The Nation Program

Indonesia Medical Association activity

International

- January 2007: Meeting with the BASICS (Basic Support for Institutionalizing Child Survival), a USAID project to fight needless childhood deaths, to develop an increase in immunization coverage in Indonesia.
- Visit Singapore Healthcare Providers initiated by the Singapore Tourism Board, with the purpose of regulating seminars on both sides..
- Meeting with JBIC (Japan Bank for International Cooperation) who is planning to assist certain universities to increase products of the medical schools .

Indonesia Medical Association activity

International

- ▣ March 2007 : MoU with AMDA (Association of Medical Doctors in Asia) for rebuilding and maintaining a health facility in Bantul, a disaster struck area in Yogyakarta Province
- ▣ April 2007 : UPLIFT International offered a grant to study in the University of Washington, which will be for nine months.

Indonesia Medical Association activity

International

- ▣ June 2007 : another visit by JBIC, talks about the possibility of providing University of Indonesia with a modern teaching hospital.
- ▣ June 2007 : another meeting with UPLIFT . Talks about IMA participating in a program to teach children in religious schools to live clean and healthy, like for example teaching children to have breakfast, which is their rights.
- ▣ June 2007 : Signing of MoU for cooperation between IMA and STB



JAPAN MEDICAL ASSOCIATION



Kazuo IWASA*¹

Grand Design 2007 Published by the JMA

The JMA recently published a policy analysis document titled “Grand Design 2007” based on the discussions with the JMA Research Institute study group on the future of Japanese healthcare. This grand design lays the analytical foundations for state finances overall in order to give direction to the reconstruction of the health insurance system and discusses total analysis of national finance to see how healthcare as the core of social security should be treated in the future. Based on these two pillars, we are trying to evaluate the current healthcare provision system to find most appropriate way of how the environment to ensure quality healthcare should be provided and discuss the most appropriate way of the cost sharing by the Japanese people for healthcare. Of these, the general statement will be published in English translation in the JMA Journal of the Japan Medical Association in installments, and we encourage you to read it.

The 27th General Assembly of the Japan Medical Congress

The General Assembly of the Japan Medical Congress met in Osaka in April 2007. Its themes were “life, people, and dream,” and 25,000 people attended it. The General Assembly meets once every 4 years. Its first meeting was in 1902, and this year was its 27th meeting. The General Assembly now has a tradition of over 100 years. During the period of this General Assembly, the officers of the Korean Medical Association in charge of scientific affairs visited Japan and conducted an exchange of opinions with JMA officers including myself.

JMA Research Institute Celebrates 10th Anniversary

This year the JMA Research Institute, the JMA think tank, celebrates the 10th anniversary of its foundation, and an event was held in April to mark the occasion. Dr. Michael Reich, Taro Takemi Professor of International Health at the Harvard School of Public Health, and Mr. Keizo Takemi, then Vice Minister of Health, Labor and Welfare, joined Dr. Yoshihito Karasawa, President of JMA for a panel discussion on healthcare. People interested will also find this content published in the JMA Journal.

WMA Medical Ethics Manual

In 1999 the WMA reached agreement to publish its own medical ethics manual, and the English version was accordingly completed in 2005. Individual national medical associations have been preparing translations of this English version in their own national languages and distributing them at a national level to people involved with healthcare and legal affairs. The Japanese version is the 13th produced. Copies were donated to the 160,000 members in Japan and to all current medical school students. We understand that it is widely used as a textbook in ethics training provided to clinic and hospital staff in Japan.

Indonesia Tsunami Recovery Support Project

The JMA collected over 60 million yen or 500,000 US\$ in donations for Indonesia to assist with recovery from the 2005 Indian Ocean earthquake and allocated this sum through the Asian Medical Doctors Association or AMDA towards the establishment of a healthcare center in the suburbs of Jogjakarta, Indonesia. Dr. Ishii, as

*1 Vice-Chair of Council, World Medical Association. Vice-President, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

CMAAO Secretary General, visited Indonesia last March in order to exchange memorandum

of understanding with the Indonesian Health Ministry and the Indonesia Medical Association.

Pattaya, Thailand

CMAAO Country Report

Kazuo Iwasa, MD
Vice President, Japan Medical Association
Vice-Chair of Council, World Medical Association
November 19, 2007

Japan Medical Association

Grand Design 2007

Policy analysis document on the future of Japanese health care was published by the JMA.

This grand design...

- *lays the analytical foundation for state finances overall in order to give direction to the reconstruction of the health insurance system.*
- *discusses total analysis of national finance to see how health care as the core social security should be treated in the future.*

➔ The Grand design in English translation is available in the JMA Journal.

Japan Medical Association

The 27th General Assembly of the Japan Medical Congress




Opening Ceremony **Scientific Session**

- *Venue: Osaka, April 2007*
- *Theme: "Life, people, and dream"*
- *Participants: 25,000 people*
- *The General Assembly has a tradition of over 100 years.*

Japan Medical Association

JMA Research Institute celebrates 10th Anniversary

The JMA Research Institute celebrates the 10th anniversary of its foundation, and the event was held in April to mark the occasion.




Panel discussion on healthcare

➔ The discussion is published in the JMA Journal.

Japan Medical Association

WMA Medical Ethics Manual

- *1999: The WMA reached agreement to publish the medical ethics manual.*
- *2005: The English version was published.*
- *2007: The Japanese version was completed as the thirteenth language version.*

Copies of the Japanese version were donated to 160,000 JMA members and all the current medical students.

Japan Medical Association

Indonesia Tsunami Recovery Support Project

The JMA collected over 500,000US\$ in donation for Indonesia to assist with recovery from the 2005 Indian Ocean earthquake.




The donation was used through the Asian Medical Doctors Association (AMDA) to establish a healthcare center in the suburbs of Jogjakarta, Indonesia.

Japan Medical Association

KOREAN MEDICAL ASSOCIATION



Dong Chun SHIN*¹

Government's Plan to Develop 'Medical Industry' and Revision of Medical Law

In 2005, the Korean government launched its strategic plan to develop the medical sector into a core future industry in Korea and has continued with follow-up measures to support the plan. The measures include diversification of for-profit-business of hospitals, establishment M&A procedures for hospitals, development of high-tech medical industry complexes and promotion of private health insurance. These measures require institutional support in the form of an all-out revision of the Korean Medical Law, which was last revised 30 years ago. KMA agrees in principal to the government's direction of active medical area promotion but at the same time emphasizes that measures to prevent negative impact on underprivileged people should come first. KMA also expresses concern that the government's plan is focused only on the hospital-level and doesn't include strategies to strengthen financial structures of clinic-level medical services. Moreover, the plan cannot become fundamental measures because it fails to address issues such as improvement of regulations, review of underestimated physician fee and increase of social health insurance contributions. Regarding the proposed bill of the Medical Law revision, KMA clearly opposes it, as some provisions impose too heavy legal obligations on physicians and some raise serious concern by expanding the scope of practice by non-physician professionals. For instance, the bill stipulated that the obligation to explain to patients is a 'legal duty.' The KMA's position is that this obligation is considered a 'moral obligation' of physicians and should be dealt in the area of medical ethics. The bill also drafted a new stipulation banning on false keeping of medical records. False keeping of medical

records can be dealt with within the concept of "fraud" on the current criminal law and reckless establishment of another penal stipulation may result in overuse of administrative disposition. KMA is planning to further keep a keen eye on the proceedings of the bill and continue to express its stance to the government.

Criticism on Government's Plan to Enforce Generic Prescribing

The government announced the plan to urge physicians to issue generic prescribing as a way of reducing health expenditure. One of the biggest cost increases in Korean health care is prescription medications. On average, medications accounted for over 30% of the total health insurance expenditure in 2005. KMA warned the government that rushed enforcement of generic prescribing without proper infrastructure and stringent institutional requirement to ensure the safety and quality of generics would harm people's health. It was found in 2006 that some bioequivalence test results of generics were fabricated by the inspecting institutions. As a result, their marketing approvals were cancelled. The Korea Food and Drug Administration (KFDA) is currently re-inspecting the bioequivalence of generics previously approved. However, notwithstanding this circumstance and KMA's concern, the government went ahead with a pilot program of generic prescription starting with the National Medical Center (NMC) in September 2007. Another concern of KMA is generic substitution. Generic substitution may undermine the relationship between doctors and patients. Doctors face difficulties in treating patients, because changes in medication can influence compliance with the course of treatment. During the first 2 months of the pilot program, only 29 % of the patients subject to generic prescribing

*1 Executive Board Member, Korean Medical Association. Professor, Department of Preventive Medicine, College of Medicine, Yonsei University, Seoul, Korea (intl@kma.org).

have been actually prescribed by generic names. KMA believes this low rate of compliance is a clear reflection of the concerns Korean physicians have about this new approach. KMA will continue to monitor the re-inspection process of KFDA to ensure the safety and quality of generics and keep members and the public informed about the risk of hasty enforcement.

Controversies over a Bill on Medical Malpractice Law

The National Assembly Sub-committee on Legislation passed a draft bill on Medical Malpractice Law in August 2007, imposing the burden proving no-fault on physicians. Efforts to legislate a Medical Malpractice Law have existed for 20 years in Korea, but an agreement was never reached due to its strong ramifications on the behavior of physicians, the quality of medical services and thus on the entire health care system. The 2007 draft bill reflected opinions of civil groups to a great extent in the following controversial issues: 1) imposing the burden of proving no-fault on physicians and 2) changing arbitration to a voluntary process. (Medical malpractice arbitration committee will be established, but whether to bring individual cases to the committee depends on patients' decisions. This means that patients can file a lawsuit without going through an arbitration process)

KMA expressed clear opposition to this draft bill. Imposing the burden of proving no-fault on physicians will result in passive and defensive medical treatment and avoidance of specialties which involve a high possibility of medical malpractice among trainee for residency.

This bill failed to be submitted to the plenary session of the National Assembly and was automatically annulled with the end of the term of the National Assembly this year. However, the lawmaker who proposed this bill is expected to introduce the bill again next year. KMA will continue to make clear its stance and concerns on the bill to lawmakers and the public. It plans to draft a separate bill which defines the burden of proving no-faults based on general principles and maintains an obligatory process of arbitration.

Preparation for 2008 WMA General Assembly

The KMA will host the 2008 World Medical Association (WMA) General Assembly in Seoul next year (The Shilla Hotel) from October as a part of celebrating its centennial anniversary. With the assembly only one year away, KMA is pulling an all-out effort for the successful hosting. Promotional materials (video, poster and leaflet) were presented at the 2007 WMA Copenhagen General Assembly held last month, which attracted participants' attention from various countries. At the assembly, the proposed theme for the scientific session "Health and Human Rights" was approved. The preparation committee is now working on a detailed program and inviting renowned speakers for each session. A photo exhibition displaying the history of KMA and medical societies is planned in parallel with the Assembly. It will become an opportunity to look back on the traces of the medical development in the last century and to set future priorities and strategies for the next century.



Country Report
Korean Medical Association
The 25th CMAAO Congress and
the 43rd Council Meeting
November 18-20, 2007, Pattaya, Thailand

Presented by **Dr. Dong Chun SHIN**
Executive Board Member, KMA
Professor, Department of Preventive Medicine, Yonsei University

1. Government's plan to develop 'medical industry' and revision of Medical Act

1) The Government's strategic plans for developing 'medical industry'

- Objective: medical industry as one of the future core competence of Korea
- Follow-up measures: diversification of for-profit-business of hospitals, establishment of procedures for M&A among hospitals, development of high-tech medical industry complex, institutionalization of private insurance and etc.

⇒ **These measures require of the revision of the Medical Act of Korea**



Korean Medical Association

1. Government's plan to develop 'medical industry' and revision of Medical Act

2) KMA's stances

- In principal, it agrees to the Government's direction to intensively foster medical area.
- Concerns on negative impact on underprivileged people
- The plan is focusing only on hospital-level
- The plan cannot be fundamental measures unless it doesn't deal with improvement in regulations, increase of social health insurance contributions, etc.



Korean Medical Association

1. Government's plan to develop 'medical industry' and revision of Medical Act

3) KMA's opposition against the proposed bill of Medical Act revision

- Obligation of explanation to patients as 'legal duty' rather than as 'moral obligation'
- Additional criminal stipulation banning false keeping of medical records : possibilities of overuse of administrative disposition

⇒ Too heavy legal obligations on physicians
⇒ Concerns on expanding scope of practice by non-physician practitioners



Korean Medical Association

2. Criticism on Government's plan to enforce generic prescribing

1) Rush enforcement of generic prescribing

- The Government urges physicians generic prescribing as a way of reducing health expenditure
- KMA's concerns
 - Not proper infrastructure : Cases of fabrications of bioequivalence test results and re- inspection by Korea Food and Drug Administration (KFDA) of bioequivalence for generics
 - generic substitutions



Korean Medical Association

2. Criticism on Government's plan to enforce generic prescribing

2) Pilot program of generic prescribing

- The Government applied a pilot program of generic prescribing starting with National Medical Center (NMC) in September 2007
- About 30% of the patients subject to generic prescribing have been actually prescribed generically.
- KMA's further measures
 - continue to monitor the re-inspection process of KFDA
 - keep members and public informed about the risk of rush enforcement of generic prescribing system



Korean Medical Association

3. Controversies over a bill on Medical Malpractice Law

1) Background

- Establishment of Medical Malpractice Law has been proposed and reviewed over twenty years in Korea, but agreements were never reached
- The preliminary committee on legislation, National Assembly of Korea passed a bill on Medical Malpractice Law in August 2007.



3. Controversies over a bill on Medical Malpractice Law

2) Controversies over the bill

- Imposing the responsibility of proving no-fault on physicians
⇒ This might result in passive and defensive medical treatment and tendencies to avoid specialties of highly exposed to medical malpractice.
- Process of arbitration on voluntary basis
⇒ This means that patients can file a lawsuit without going through an arbitration process first



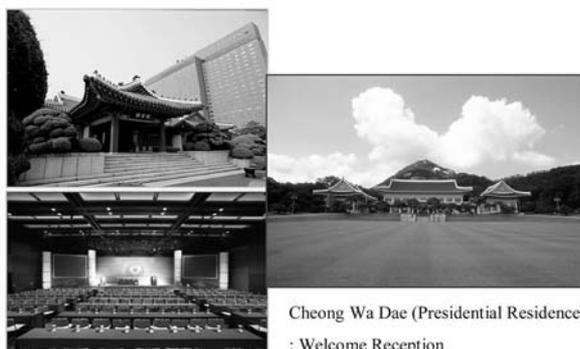
4. Preparation for 2008 WMA General Assembly Seoul 2008

1) Overview

- Date: October 15(Wed.)~18(Sat.)
- Place: Hotel Shilla, Seoul, Republic of Korea
- Main Program
: Council Session, Scientific Session, Assembly Ceremonial Session, Plenary Session of Assembly
- Theme of Scientific Session : “ Health and Human Rights”
- Social Events
: Welcome Reception hosted by the President of Korea, Dinner hosted by KMA, City tour, Dinner hosted by WMA



4. Preparation for 2008 WMA General Assembly Seoul 2008



Hotel Shilla and Main Meeting Room

Cheong Wa Dae (Presidential Residence)
: Welcome Reception



4. Preparation for 2008 WMA General Assembly Seoul 2008



Glimpse of Seoul- Royal Palace



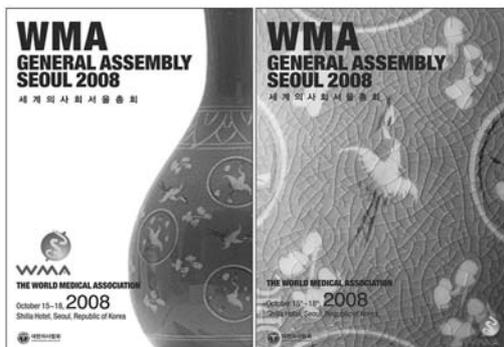
4. Preparation for 2008 WMA General Assembly Seoul 2008



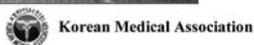
Glimpse of Seoul- Central Area for Commerce



4. Preparation for 2008 WMA General Assembly Seoul 2008



Promotional Posters



5. Tobacco cessation campaign

Education Programme for physicians

- Provision of education to physicians to help and guide tobacco cessation of patients and physicians themselves
- Promoting awareness of importance of physicians' role in tobacco cessation
- Series of workshops for physicians rotating provinces
- KMA will diversify and expand the programme in 2008 to provide education opportunities to more members



Thank you.



NEW ZEALAND MEDICAL ASSOCIATION



Peter FOLEY*1

New Zealand's health sector has been radically transformed over the past decade and a half. Successive governments with different perspectives and ideologies have made huge structural changes. The current Labour-led Government, headed by Prime Minister Helen Clark, is now 2 years into its third 3-year term, and is in a phase of consolidation rather than implementing new initiatives. This Government now faces a strong challenge from the main Opposition party, which is leading in the polls.

Over the past 15 years democratically-elected regional hospital boards have been set up, abolished and replaced by commercial companies, and then re-introduced. New Zealand now has 21 District Health Boards (DHBs) which are responsible for providing government-funded health care for the population in their region. DHBs focus on planning and delivering health services, running hospitals, overseeing primary health care services and delivering some public health programmes.

Adequacy of funding at District Health Board level is a continuing concern, with some running continual deficits and/or cutting services to meet budget constraints. The continuing inability of many DHBs to meet their commitments in respect of patient access to secondary and tertiary services continues to be of great concern. This is particularly so in relation to first appointment with specialists, and the long waiting times for many elective procedures. The situation is further complicated by the returning of many patients from hospital waiting lists to the care of their GP. This lack of timely access to the care they need causes great distress to many New Zealanders and their families.

Care in the private secondary health sector is available to those with health insurance or the means to pay. More than 50% of elective surgery takes place in the private sector, as funding restraints and restricted waiting lists mean only

the most urgent cases get priority in public hospitals. A major issue has been the removal of subsidies, in some regions, for patients of private specialists who require laboratory tests. The NZMA believes this is inequitable and unfair both to the patients and private specialists.

Medical registration in New Zealand is controlled by the Health Practitioners Competence Assurance Act 2003, which brought together all registered health practitioners (such as doctors, nurses, dentists, midwives and physiotherapists) under the same registration, competency and disciplinary procedures. The Act has the primary aim of protecting the public. Of great concern to the NZMA is the fact that although the Act permits regulations to be made which would allow for elected members to the Medical Council of New Zealand (MCNZ), to date, the Minister of Health has not done so. For the MCNZ to work effectively it must have the respect and confidence of the profession, and that will not happen while there are no directly elected members.

The medical workforce in New Zealand continues to be under extreme stress. The high fees and resulting debt levels incurred by medical students in training lead to many newly-qualified New Zealand doctors seeking higher-paid positions overseas. Other problems include:

- Increasing demand
- Ageing workforce
- Doctor dissatisfaction and morale leading to retention issues
- Insufficient medical student places (self-sufficiency is needed)
- Student debt
- Long lead time to train doctors
- Generational changes in work-life balance expectations
- Inappropriate reliance on overseas trained doctors (OTDs)

Many of New Zealand's practising doctors

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trained elsewhere in the world—currently 42% are from overseas countries. Doctor shortages in some regions and notably in rural areas continue to place extra demands on the profession. Specialities such as obstetrics, psychiatry and general practice are particularly short. The Government has established a Medical Training Board to find solutions to workforce problems. The NZMA has long called for a comprehensive strategic plan for the medical workforce which will address both the short and long term need for medical practitioners in New Zealand.

Seven years ago the Government released its Primary Health Care Strategy, based on capitated funding to general practices which enrol their patients as members of a Primary Health Organisation (PHO). PHOs receive public funding through District Health Boards. This was the biggest shake-up of the primary health sector for half a century.

The New Zealand Medical Association supported the broad proposals of the Primary Health Care Strategy as having the potential to improve the health of New Zealanders and their access to primary health services. The Government has progressively rolled out increased funding to all age groups, which has enabled patient co-payments to be reduced. We have fought hard to retain the principle that GPs be able to set their own fees, and charge a co-payment if necessary (as the government funding does not cover the entire cost of visiting a GP). The control of GP fees is shaping up to be a major election issue.

The NZMA continues to publish the New Zealand Medical Journal, which has been online only since 2002. The NZMJ is the premier scientific medical journal for the profession in New Zealand, and continues to publish well regarded research on a wide variety of medical topics.

The NZMA provides the Code of Ethics for the profession in New Zealand, and has been reviewing the Code this year.

The NZMA works closely with the NZ Medical Students' Association, recognising that students are the future of the profession. The NZMA also has a Doctors-in-Training Council, which represents the interests of junior doctors and medical student members.

Other NZMA initiatives include:

- Around 50 submissions on a wide variety of issues.
- Running a successful Trainee Forum, with participation from registrars from many of the Medical Colleges.
- The establishment of a Leadership Fund to support participation in leadership activities.
- Settling the largest multi-employer collective employment agreement ever to be negotiated in New Zealand (representing GPs as employers of practice nurses).
- Launching a new publication—the NZMJ Digest.
- Producing a member resource on the Commerce Act, to enable medical practitioners to develop an understanding of competition law and practise safely within the confines of the law.

It has been another busy and challenging year for the NZMA. We place a high value on advocacy for the health of the population and support for professional conditions. Continuing liaison with health sector policy makers, representation on consultative bodies, preparation of submissions on health-related legislation and advocacy about the introduction of new initiatives continue to keep members actively engaged in improving health care for all New Zealanders. We continue to work closely with other medical organisations both within the country and at an international level.

SINGAPORE MEDICAL ASSOCIATION



Yik Voon LEE*¹



COUNTRY REPORT

Presented by

Dr LEE Yik Voon
Honorary Treasurer, 48th Council
Singapore Medical Association

25TH CMAAO CONGRESS & 43RD CMAAO COUNCIL MEETING
18 – 20 NOVEMBER 2007, PATTAYA



Membership



- ❖ As at 30 September 2007, total membership of the Singapore Medical Association stood at **4,917**.
- ❖ This represents **68%** of all 7,288 registered practitioners in Singapore.



48th SMA Council 2007/8

President	Dr WONG Chiang Yin
1st Vice President	Dr CHONG Yeh Woei
2nd Vice President	Dr TOH Choon Lai
Honorary Secretary	Dr Raymond Chua Swee Boon
Honorary Treasurer	Dr LEE Yik Voon
Honorary Asst Secretary	Dr WONG Tien Hua
Honorary Asst Treasurer	Dr Abdul Razakjr OMAR

Members

Dr Tammy CHAN Teng Mui	Dr TOH Han Chong
Dr CHIN Jing Jih	Dr Bertha WOON Yng Yng
Dr LEE Pheng Soon	Dr YEO Sow Nam Alex
Dr TAN Sze Wee	Dr YUE Wai Mun



Conventions & Seminars

13th SMA House Office Seminar

- ❖ Held on 21 April 2007.
- ❖ Attended by more than 100 graduating House Officers.
- ❖ Talks included "Morning Ward Rounds", "Changes", "What Makes a Good House Officer" & "Medical Indemnity".



*1 Honorary Treasurer, 48th Council, Singapore Medical Association, Singapore (sma@sma.org.sg).



Conventions & Seminars




Conventions & Seminars

38th SMA National Medical Convention

- ❖ 19 & 20 May 2007.
- ❖ Theme: "Breaking New Barriers in Pain Management".
- ❖ Aims:
 - Raise awareness of pain medicine as multidisciplinary.
 - Provide forum to discuss pain objectively and openly.
 - Update fellow colleagues on current trends.
- ❖ Keynote address by Mdm Halimah Yacob, Member of Parliament and Chairman of the Government Parliamentary Committee (Health)



Conventions & Seminars

- ❖ Special lecture on "*Chronic pain: Is it a disease entity? IASP's role*" by Prof Troels Staehelin Jensen, President of the International Association for Study of Pain (IASP)
- ❖ Plenary session on "*Impact of pain in Asia and how we cope*", with presentations from Australia, Singapore, China, Japan and Malaysia
- ❖ Medical symposium on "*Breaking new barriers in pain management*", with presentations on pharmacological and interventional approaches to cancer pain, arthritis, headaches, back and neck pain, neuropathic pain, and opioids and NSAIDs for chronic pain.



Conventions & Seminars

- ❖ Lunch symposium on "*The use of COX-2 inhibitors in NSAID intolerant patients*"
- ❖ Workshop on "*Dealing with Opioids in chronic pain*" and "*Acupuncture and needling*"
- ❖ Public forum on "*Overcoming pain with the latest medical breakthroughs*". Chinese translations were also provided to cater to the large number of Mandarin-speaking public who attended.



Conventions & Seminars




Conventions & Seminars

Flu Pandemic Workshops

- ❖ Held over 3 weekends from August to September 2007.
- ❖ Attended by almost 700 participants.
- ❖ Jointly organised by Ministry of Health, SMA and College of Family Physicians Singapore.
- ❖ Aim of workshops was to support GPs who would continue to manage the sick in the community during a pandemic.



Conventions & Seminars

- ❖ Presentations included:
 - latest updates on avian influenza situation and the systems and operational procedures that will come into effect in the event of a pandemic
 - practical steps on how to prepare clinics to handle suspected cases
 - personal protective equipment and mask-fitting
- ❖ GPs were also encouraged to sign up for the Primary Healthcare Response Framework. In event of a pandemic, GPs will continue to provide clinical assessment and antiviral treatment when needed or make referral to hospitals for further treatment. Participating GPs and their clinic staff will receive same level of protection as healthcare workers in public sector and will be provided with antiviral drugs for treatment purposes.



Conventions & Seminars

11th SMA Annual Ethics Convention

- ❖ 19 & 20 October 2007
- ❖ Theme: "*Managing Risks in Medical Tourism & Aesthetics Practices*"
- ❖ Opening Ceremony on 19 October 2007 was held in conjunction with the Launch of the Medical Protection Society (MPS) Educational Services.
- ❖ Following the acquisition of Cognitive Institute in March 2007, MPS Educational Services is expanding their risk management and training portfolio, allowing them to offer more educational programmes to MPS members around the world.



Conventions & Seminars

- ❖ Presentations on 20 October 2007 included:
 - "*Managing Risks in Medical Tourism and Aesthetics Practices*"
 - "*Enhancing Communications and Informed Consent in Medical Tourism & Aesthetics Practices for Better Doctor-Patient Relationships*"
 - "*Ethical Issues in Aesthetics Practices*"
 - "*Dealing with Medical Tourism Overseas – The Do's and Don'ts*"



Conventions & Seminars



Conventions & Seminars

SMA Lecture 2007

- ❖ 24 October 2007
- ❖ SMA Lecturer 2007: Professor Woo Keng Thy
- ❖ Theme: "Physician Leadership". Highlights included:
 - Fundamental advantages a doctor has over others in leadership positions, including the study and understanding of human nature.
 - Essential qualities in a strong leader, with examples from Art of War by Sun Tzu
 - The importance of change and exiting leadership.



Conventions & Seminars

AST Course on Medical Ethics, Professionalism & Health Law

- ❖ Compulsory requirement for exit certification from specialist training.
- ❖ Equip trainees with necessary communication skills & working knowledge of clinical ethics & local health statutes.
- ❖ Help trainees develop more systematic & professional approach to common ethical & medico-legal issues in Singapore.





Publications & Reports

Monthly/Bimonthly Publications

- ❖ Singapore Medical Journal
- ❖ SMA News
- ❖ Sensory (bimonthly)



Publications & Reports

Withdrawal of SMA Guideline on Fees

- ❖ SMA announced the withdrawal of its Guideline on Fees (GOF) at its AGM on 1 April 2007 with immediate effect.
- ❖ The decision was made by the 48th SMA Council after it received indications that the GOF might contravene Section 34(2)(a) of the Competition Act, and also after the Council had sought advice from 5 of its Honorary Legal Advisors.



Publications & Reports

- ❖ The GOF was first introduced in 1987 with the aim to:
 - Protect patients from being overcharged and to equip them with knowledge on medical procedures in the hope that with improved knowledge there would be lesser cases of misunderstandings.
 - Help doctors with an indication of the current rates and how much to charge their patients.



Publications & Reports

- ❖ In the meantime, SMA will be conducting surveys on clinic charges and professional fees of GPs and specialists and will publish the data before its next AGM in 2008.
- ❖ The defunct SMA Tent Card, which provided a display of consultation charges under the GOF, will be re-issued with blanks for doctors to fill in their own clinic charges and professional fees.
- ❖ SMA is also working with the Law Society of Singapore to jointly re-issue a separate advisory entitled "Best Practices Guidelines for Court Attendance and Preparation for Medical Practitioners". This advisory will be circulated to members of SMA and Law Society, for the purpose of promoting good work relationships between medical and legal practitioners.



Social Concerns

SMA Medical Students' Assistance Fund

"There is really no more relevant cause to us than helping our poor youths who desire and deserve a meritocratic medical education."

Dr Wong Chiang Yin
President, 48th Council
Singapore Medical Association



Social Concerns

SMA Medical Students' Assistance Fund

- ❖ To help poorer medical students with their basic living expenses. Fund set up in partnership with the National University of Singapore's (NUS) Yong Loo Lin School of Medicine and with support of NUS Development Office.
- ❖ Recent survey by NUS Medical Society found that about 21%, or 250 medical students in the NUS undergraduate course, have a monthly household income of less than S\$3,000. Another 26% come from households that earn between S\$3,000 to S\$5,000 a month.
- ❖ A NUS medical student needs at least S\$4,410 a year to survive day-to-day (transport, food, books, etc), or **S\$367.50 a month**.



Social Concerns

- ❖ While there are a number of bursaries, financial assistance schemes and loans which can help pay for tuition fees, basic living expenses are not always covered.
- ❖ Some students have managed by giving tuition but at the expense of their own studies.
- ❖ Fundraising activities include appealing for monetary donations from SMA members, hospitals and charitable foundations, as well as selling SMA Christmas cards.
- ❖ SMA will also be engaging medical students more actively through NUS Medical Society, e.g. SMA has offered SMA student memberships to final year students, mentorship scheme, inviting students to SMA events, etc.



TAIWAN MEDICAL ASSOCIATION



Ming-Been LEE*¹

Installment of Taiwan Medical Association's New President and Executives

Taiwan Medical Association held the presidential election at the first Representative Congress of the 8th term in May of 2007. Dr. Ming-Been Lee won majority votes from the representatives and councils and was installed as the new president of Taiwan Medical Association. In order to undertake our responsibilities as a member of the global society, Dr. Lee stresses his desire to strengthen the communication with other medical associations and to share Taiwan's medical system and experience through frequent interactions.

Taiwan Medical Association Was Awarded the 2006 Excellent National Professional Organization by Ministry of the Interior

In order to strengthen the function and structure, and enhance the development of professional organizations, Ministry of the Interior in Taiwan hosted an "Excellent National Professional Organization" performance screening. Taiwan Medical Association stood out from among 7,800 organizations and was awarded by the Minister of the Interior for the following reasons: Aggressively participate in cooperative plan hosted by the Department of Health and WMA activities; undertake physician clinics global budget task; build global informational network; assist in physicians' national insurance enrollment, payment and brochures' edition; establish medical dedication award to cite for physicians' exceptional distribution to the health care industry; assist DOH in drawing up "Patient Safety Guidelines" as a reference to patients and families.

Striving for Medical Reconstruction Fund

The increase of aging population, numbers qualify for serious injury and the introduction of new medical technologies have all contribute to the annual 8–10% medical expenditure growth rate. The financial difficulty is extremely urgent. However, the Bureau of National Health Insurance has strengthened its control over health care facilities. The model it uses to control the payment system contradicts with market mechanism and has led to a twisted and restrained future for the health care development.

In 2005, the health care expenditure counted for 6.16% of GDP in Taiwan. This is significantly low compare to 8% in OECD countries and 15.3% in the U.S.A. There is no doubt that Taiwan is offering high quality health care services with insufficient resource. Nevertheless, health care facilities face a discounted payment system. This will danger the health care system if it induces the health care facilities to collapse and the providers to break down.

In order to maintain the health service quality, improve peoples' habit of accessing health care services and health care system default, hold the public health system together, assure patients' right to access health care services, we have been striving for the government to budgeting the "medical reconstruction fund" for 2 years. The main purpose is to add the budget to the unbalanced global budget payment system. The premier has finally agreed our appeal for 50 billion dollars "medical reconstruction fund" budget in September of 2007.

Insurance Certification—IC card

Taiwan introduced National Health Insurance in 1995. With the need of informationize, insurance

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certification evolved from paper into IC card in 2004 and the first stage registration and uploading was implemented at the same time. In order to increase the accuracy of medical information, reduce the consumption of medical resources, monitor health care facilities that patients access and assist in the implementation of various prevention measures, the Bureau of National Health Insurance in Taiwan adopted a disciplinary and rewarding method to request health care facilities to cooperate with second stage registration and uploading in 2007. The main contents include primary and secondary diagnosis, medication, physician orders, fees...etc. However, Taiwan Medical Association continues to negotiate with Department of Health and the Bureau of National Health Insurance not to force the implementation by using disciplinary way due to the suspicion from different facets such as: facilities' settlement, ability to handle information and the doubt of service quality, ethics, privacy, legal and practical operation. We are still continuing our talks with other parties in order to reduce the impact this has caused to health care facilities.

Taiwan Medical Association Signed a Memorandum of Understanding with the Argentina Medical Association

Taiwan Medical Association signed a bilateral

Avian Flu cooperative memorandum of Understanding with Dr. Jorge Carlos Janez, President of the Argentina Medical Association, in April of 2007 based on the standpoint of "diseases without borders." The main purpose is to bring NGO's participation in international epidemic prevention into play through both organizations' interaction and cooperation with the hope to assist people and government from both countries to completely prevent avian flu from happening again.

Taiwan Medical Association's Representative Made a Keynote Speech in 2007 World Medical Assembly

Dr. Heng-Shuen Chen from the Taiwan Medical Association was invited to be the speaker of 2007 World Medical Assembly Scientific Session on the topic "e-Health Solutions for Systems in Development."

Dr. Chen gave a detail introduction on Taiwan's medical technology, such as IC card, telemedicine, the development and research in telemedicine in recent years, and how to combine other information systems to promote health care quality...etc.



2006 Excellent National Professional Organization

- ❖ **Aggressively participate in cooperative plans with the Department of Health of Taiwan and WMA.**
- ❖ **Undertake physician clinics global budget task.**
- ❖ **Establish "Medical Dedication Award" to cite for physicians' exceptional contributions to the health care.**
- ❖ **Assist DOH to draw up the "Patient Safety Guidelines" as a reference to patients and families.**

3

Medical Reconstruction Fund

- ❖ **Every year, a 8~10% growth of medical expenditure due to population aging, advanced medical technology development and many other factors was noted in Taiwan**
- ❖ **In 2005, health care expenditure around the world**
 - **Taiwan: 6.16% of GDP**
 - **OECD countries: 8% of GDP**
 - **USA: 15.3% of GDP**
- ❖ **The discounted payment system had great impacts to the health care system**
- ❖ **50 billions NT dollars (1.3 billions USD) of "medical reconstruction fund" has been proposed**

4

Insurance Certification - IC Card

- ❖ **National Health Insurance in 1995**
- ❖ **First stage in 2004**
 - Patient visit data registration and uploading was implemented by IC cards
- ❖ **Second stage in 2007**
 - Patient visit registration and uploading of all claim data, including primary and secondary diagnosis, medications, physician orders, fees ...etc

5

Memorandum with the Argentina Medical Association

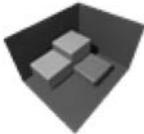
- ❖ **Diseases have no borders**
 - In April of 2007, TMA signed a bilateral Avian Flu cooperative memorandum with the Argentina Medical Association
 - Invite both GO and NGO to participate in this cooperative prevention program



6

Keynote Speech in 2007 World Medical Assembly

- ❖ **Dr. Heng-Shuen Chen from the Taiwan Medical Association was invited speak in the 2007 World Medical Assembly Scientific Session**
 - "e-Health Solutions for Systems in Development."



7

Mental health gatekeeper program

- ❖ **All 13,000 primary care physicians were invited to be gatekeepers of suicide prevention**
- ❖ **Mental health collaborative care systems for primary care physicians and mental health workers**
 - **Depression management**
 - **Dementia screening**



8

Body Donation: An act of love supporting anatomy education

JMAJ 51(1): 39–45, 2008

Tatsuo SAKAI*¹

Abstract

Cadavers for anatomical dissection in Japan are supplied totally by body donation. At present, 210,000 persons have been registered for body donation and donation of 77,000 bodies has been conducted. The supply is generally sufficient. To extend the spirit of love associated with body donation, Tokushi Kaibo Zenkoku Rengokai [National Confederation of Anatomy Body Donation] conducts PR activities using publications and lecture meetings. A distinct feature of body donation in Japan is the fact that the ashes after dissection are returned to the families of body donors. This practice reflects the strong attachment of Japanese people to the remains of deceased relatives. In Western countries, the ashes are not usually returned to the families, and donated bodies are used for various purposes, such as the study of human body damage in car crash experiments and the preparation of anatomical specimens for exhibitions. Japanese laws place restrictions on cadaver dissection with respect to place, instructors, purposes, and courtesy, and strictly limit the use of cadavers for purposes other than the education of medical students. Medical students in Japan perform dissection with deep understanding of the goodwill of body donors and the feelings of their families. This fact contributes tremendously to the effectiveness of ethical education.

Key words Medical education, Cadaver dissection, Body donation, International comparison

Introduction

Every year, a large number of students are admitted to the medical and dental faculties of colleges and universities in Japan, and experience cadaver dissection. The number of students in a year exceeds 10,000, approximately 8,000 in medicine and 2,500 in dentistry, and the number of donated bodies used in the dissection courses for them is approximately 3,500.^{1,2} The cadaver dissection course is the gateway to a medical career for almost all students aspiring to work in medicine, and the source of precious memories that are the first to be recalled when they later look back on their student days. Probably most of the 270,000 physicians in Japan dearly remember their school days with recollections of their hard

work in the dissection course and the personality of their anatomy professors.

Decades ago, the bodies used for cadaver dissection were mostly those of persons that had died from sickness without relatives. At present, almost all bodies for cadaver dissection are donated. Body donation is the act of giving away one's body after death without any conditions or rewards for the sake of education and research in medicine. When a body is donated, it takes 2 to 3 years before dissection is performed, cremation is done, and ashes are returned to the family.

Rumors were once circulated that body donation was rewarded with money or favoritism in the provision of medical services at hospitals. I do not deny the possibility that some university staff might have provided some benefits at their

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discretion in the 50-year history of body donation. However, present day body donation has nothing to do with such provision of benefits. Body donors are wholeheartedly glad that their bodies will serve the progress of medicine after death. Taking the gratuitous love of body donors, students learn human anatomy and start their first steps towards becoming fully trained physicians.³

This article, outlining the distinctive features and present state of anatomy education and the body donation movement in Japan, calls for further understanding and support of all people engaged in medicine.

Present State of Anatomy Education

With the rapid progress of medicine, medical education has been undergoing incessant drastic changes. As compared with the times when I was a student about 30 years ago and when I started to teach at Juntendo University about 15 years ago, medical students nowadays need to learn much more in the same length of 6 years.

For effective learning, textbooks and reference books have been improved to be more user friendly and direct, and the use of Power Point during lectures now helps the delivery of sufficient knowledge in a compact timetable. The means to increase the learning ability of medical students have also been introduced, such as early start of experience-based learning and small-group tutorial classes. To standardize medical education, the core curriculum was developed in 2001, and the Computer Based Testing (CBT) for measuring the achievement of medical students in Japan was introduced in December 2005. In the context of continuing change in medical education, the position of cadaver dissection requires constant revision.

The number of hours allocated to cadaver dissection and lectures in anatomy has decreased considerably. However, it always remains true that cadaver dissection is the core part of education in anatomy, and anatomy provides the foundation for the entire medical education. The greatness of the mental and physical burdens associated with dissecting human bodies also remains unchanged. As medical education has become more and more standardized and efficient, the role of the cadaver dissection course has become even more important. It provides a precious occasion for students to be confronted



Fig. 1 The first day of the cadaver dissection course in Juntendo University School of Medicine

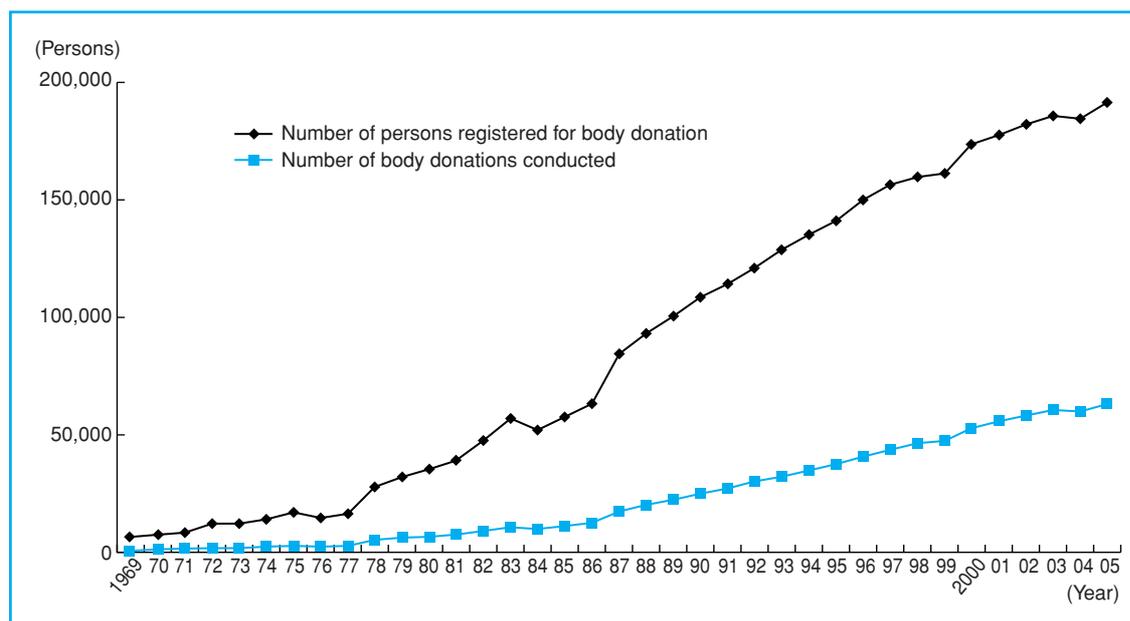
Before meeting the bodies, all attendants pray silently for the souls of body donors.

with the human body. The body of a person lying in front of them means various things for the person, for the family, and for physicians. With such thoughts in mind, students excavate nerves, blood vessels, organs, muscles, and other structures, and explore the mechanisms supporting the human body.

At Juntendo University, students of the school of medicine attend the dissection course from late October to early February in the second year. The moment when students meet the body to be dissected is full of tension. Each body on the table is a person, who has lived a life of several decades, and is lying there because he or she wanted to. Everybody in the dissection course silently prays for the souls of body donors (Fig. 1).

However, once the covering cloth is removed, and a knife cuts the skin to reveal the interior of the body, the body instantly becomes a cadaver. During the 4 months that follow, students are busy identifying and removing each and every structure constituting the human body—muscles, blood vessels, nerves, thoracic and abdominal organs, etc. They realize that the body of a person is an assembly of tangible objects. The experience of doing this using their own hands is invaluable. On the other hand, students are fully aware that the structures taken out of the cadaver are something more than physical objects. This is because they have met the body as a person with dignity, and because they themselves have changed it to an object of science called a cadaver.

On the other hand, body donors are proud



(Compiled from Tokushi Kaibo Zenkoku Rengokai: The State of Body Donation, List of Associations 2006.)

Fig. 2 Number of persons registered for body donation and number of body donations conducted, compiled from data for donor associations

of being body donors and find fulfillment in contributing to society. The late Mr. Akira Nawa, former President of “Shiraume-Kai” society of body donors to Juntendo University, used to say that he was taking good care of his body so that he could better serve medical students. The body donors to Juntendo University gather at the general meeting of Shiraume-Kai, held every year in the fall. Juntendo considers this meeting as an important occasion for expressing thanks to body donors, and the meeting is incorporated in the curriculum of second year students, who perform cadaver dissection. All second year students cooperate in the operation of the meeting as volunteers. They sit around the same tables with body donors and have conversation. Through this direct interaction, body donors are reassured of their roles in helping the development of medicine, and students understand the profound meaning of being allowed to dissect donated bodies. Thus, body donors are helping the growth of medical students, and medical students are giving a sense of fulfillment to body donors. I quote the following words by a student.

When I was in front of the body, I was intimidated by the presence called death. I felt

as if my heart was squeezed tight. Probably because I had seen the death of my grandfather, I was going to be overwhelmed by the seriousness of the meaning of death. Prompted by my mentor, I took up the knife, which felt heavy. I hesitated, because of the doubt that it might be wrong to cut into a body that should be respected, and a complete stranger like I might not be allowed to touch the body in such a way.

Encouraged by the serious undertaking of my mentors and friends, I was able to complete the course. However, I have not forgotten the anxiety and discontent I felt in the beginning.

As time passed, I came to realize the thoughts of body donors and their families who agreed on body donation. I am sure that their decisions were the result of their strong will, as well as much emotional conflict. I felt sincere gratitude for their goodwill. I wished I could bow in front of body donors in life and thank them and their families. As this was no longer possible, I thought the only thing I could do for them was to continue studying with respect and thankfulness. (From the speech by Ms. Asako Nishino, the representative of students, at the ceremony of returning

ashes of body donors for systemic anatomy, Juntendo University, 2006.)

Physicians do not often recollect the experience of cadaver dissection in their student days. Despite the fact that the dissection course had much to do with the development of their professional views on humanity and life, few consciously ask how they changed through this experience. A rare exception is the novel “Igakusei” [A Medical Student]⁴ written by Mr. Keishi Nagi in 1993. This novel describes the growth of a medical student with a vivid narrative of the memories of the dissection course.

Literary works featuring the thoughts of body donors seem to be even scarcer. The novel “Bizan”⁵ by Mr. Masashi Sada is the story of a woman who donates her body and the daughter of the woman. Their thoughts on body donation are given a substantial weight in this novel.

The Present Day Body Donation Movement

Tokushi Kaibo Zenkoku Rengokai [National Confederation of Anatomy Body Donation] is the organization formed by universities performing cadaver dissection and body donor associations in Japan. In cooperation with Nihon Tokushi Kentai Kyokai [Japan Body Donation Association], the Confederation performs outreach activities to promote the significance of body donation. It was established in 1971 against the background of a serious shortage of cadavers for medical education, and has been making active efforts to influence the government and various organizations.

Starting from 1982, body donors are presented with letters of thanks from the Minister of Education, Science and Culture (present Minister of Education, Culture, Sports, Science and Technology). The Law Concerning Body Donation for Medical and Dental Education (the Body Donation Law) was enacted and enforced in 1983. From this time, body donation became widely recognized in society, and the number of persons registered for body donation increased rapidly (Fig. 2). As of the end of March 2006, the accumulated number of persons registered for donation reached 210,605, and donation of 77,645 bodies has been realized.¹ At present, the bodies for cadaver dissection courses in medical

and dental faculties are almost completely supplied by body donation, and many universities are restricting or declining new registration for body donation.

After attaining the goal of securing a sufficient number of bodies, the body donation movement at present has two important issues that need to be addressed.

One is the realization of more enriched anatomy education through body donation. In other words, the goal is the qualitative improvement of body donation and anatomy education. To this end, the Federation is issuing various PR materials and distributing them to anatomy departments and body donor associations across Japan. Collections of writings by body donors and students performing cadaver dissection, entitled “Kaibogaku he no Shotai” [Introduction to Anatomy], are produced every year. (In 2006, the 26th volume of body donors’ writings and the 28th volume of students’ writings were published.)⁶ Another yearly publication is “Tokushi Kentai” [Goodwill Body Donation] distributed at the general meeting of the Federation. (No. 48 was published in 2006.) A manual for persons dealing with the practical aspects of body donation, entitled “Kentai no Tadashii Rikai no Tameni” [For Correct Understanding of Body Donation] (called the Body Donation Manual for short),⁷ and an informative document for persons wishing to register for body donation, entitled “Kentai Toha” [What Is Body Donation] (called the Leaflet for short), are always available on request.

The second issue is how we should permit the practice or observation of cadaver dissection in the anatomy education of co-medical students. The anatomy departments of most universities in Japan accept students from many co-medical training schools and they allow them to observe cadaver dissection without hands-on involvement in dissection. Many nursing schools operated by municipalities, medical associations, and hospitals are relying on the observation of cadaver dissection at anatomy departments of nearby universities. Through such observation of cadaver dissection, co-medical students gain first-hand experience on the internal structure of the human body and develop a sense of reverence towards the human body, similarly to the case of medical students performing cadaver dissection. Specialists in vocations involving direct contact with the

body of patients, such as physiotherapists and occupational therapists, are required to have deep understanding of human anatomy. For this reason, some institutions including national universities offer cadaver dissection courses for co-medical students including actual dissection using knives and forceps.

The legal basis for cadaver dissection performed by medical students is the Law Concerning Cadaver Dissection and Preservation enacted in 1949. It stipulates that dissection must be conducted in appropriate places (in anatomy dissection rooms), with instruction by appropriate teachers (by professors and associate professors in anatomy), and for appropriate purposes (to serve for medical and dental education). In addition, the Law demands that bodies must be handled respectfully. Although the expression is abstract, the ethical issue of the respect of a person's body is addressed as a crucial matter. At present, the observation and practice of cadaver dissection for co-medical education are conducted under the responsibility of professors in anatomy, respecting the spirit of the Law Concerning Cadaver Dissection and Preservation and within socially acceptable ethical boundaries.

Distinct Features of Anatomy Education and Body Donation Movement in Japan

Body donors provide their bodies after death without any conditions or rewards, and students gratefully use their bodies without inconvenient limitations. Although this is taken for granted in Japan, situations in other countries differ completely. In the United States and European countries, the almost overabundant number of bodies is supplied through body donation, and the donated bodies are used for various purposes. The ashes after dissection are usually not returned to the families of the body donors.

Particularly in the United States, the uses of bodies extend widely beyond the scope of ordinary medical education. While an advantage is the possibility of the study of clinical anatomy using fresh frozen bodies, bodies are also used for various non-medical uses that are not imaginable in Japan. For example, bodies are reported to have been used in car crash experiments examining the damage to the human body for the purpose of improving safety devices on automobiles, and in experiments examining the impact of

bullets and bombs on the human body for the purpose of improving protective body armors.^{8,9} In addition, a person managing the body donation program at the University of California Los Angeles was arrested for smuggling cadavers in 2004.

In Germany, restrictions on cadaver dissection are relatively weak. Private laboratories accept many donated bodies and produce plastinated specimens from them. These are presented at the exhibition called BODY WORLDS in various countries. Displaying cadavers arranged in various poses, such as riding a horse and playing chess, this exhibition has been the focus of much controversy. The German Anatomical Society has officially issued a statement against this exhibition.¹⁰

China has no system of body donation, and medical students are unable to perform necessary cadaver dissection. Chinese students visiting Japan often admire the excellent cadaver dissection courses in Japan. On the other hand, there are workshops producing plastinated specimens in various locations in China. Although the origins of the cadavers are unknown, many anatomical specimens produced at such workshops are exported. Commercial-based human anatomy exhibitions using Chinese-made specimens are held in Japan and Korea, attracting many visitors.

In Taiwan, a body donation movement was commenced by Tzu Chi Medical School (present Tzu Chi University) operated by a Buddhist foundation. However, the shortage of cadavers still remains unsolved.

Body donation in Japan is an excellent practice that has no counterparts in the world. We have an ideal education environment, in which students can perform dissection using the abundant supply of cadavers filled with the love of body donors and their families. This is the fruit of the efforts made by body donors and university personnel that have supported the body donation movement, as well as the understanding and support of the public. Anatomists in Japan are also fully responding to such efforts. While anatomists in the United States and Europe tend to focus on biological study and stay away from education in anatomy, those in Japan are keeping the balance between education and research and accomplishing considerable achievements in both aspects.

While plastinated specimens have great educational value, importation of plastinated speci-

mens produced in other countries can be a form of cadaver trade unless certain restraints are used. It is difficult to produce plastinated specimens in Japan, because body donors are not ready to agree on such use of their bodies.

Towards the Future of Anatomy Education and the Body Donation Movement

Even if body donation and anatomy education in present day Japan are praiseworthy, there are many difficult problems to be solved for the future. The support and understanding of the medical community and the public are still required.

The first problem is the scarcity of young anatomists who are to support the education and research in anatomy. This problem is not unique to anatomy, but is shared by all fields of basic medical sciences. However, the training of anatomists is not a matter of learning techniques from manuals, and it depends more heavily on the accumulation of experience than that in other fields. In operating a cadaver dissection course, one need not only perform dissection in the dissection lab, but must also deal with various delicate tasks, such as communicating with persons registering for body donation, responding to the family and receiving the body, applying preservative treatment to the body, conducting memorial services and body donors' meetings, and returning the ashes to families. Experience is also important in such peripheral tasks.

The second problem is the rapid destabilization of the education and research environment at universities, which is further complicating the situation. The working budget is compressed, and researchers are encouraged to acquire competitive research funds. The conversion of public and national universities to independent administrative institutions also resulted in the tightening of the budget. It is virtually impossible to take the first step of a research program using a university's own research funds.

Much of the time and labor of anatomists are spent on education in the cadaver dissection course, leaving very little for research. In addition, although anatomical studies are quoted in other works over a long period of time and their influence is widespread, they are disadvantaged in terms of the impact factor and the effectiveness in raising research funds. There is a clearly grow-

ing tendency that the appointment of new professors is made based on the volume of research achievements and the ability to raise research funds. In the present environment, researchers in basic medical sciences are hard pressed to produce immediate results in research, giving up education. This is a result of the competitive principle working only in the aspect of research achievements, which are easy to evaluate objectively. On the other hand, objective evaluation is difficult in the aspect of education, including the character development of medical students. In the face of this reality, anatomists supporting anatomy education are increasingly becoming wary of making efforts.

The third problem in anatomy education is the presence of many risks, which are inseparably related to educational effects. Prevention of infection from bodies before preservative treatment, protection of students and teaching staff against the health hazard of formalin from cadavers, emotional conflicts with body donors and their families, judgment about cadaver dissection courses for co-medical students, imprudent comments on cadaver dissection incited by mass media, and many other issues need to be addressed. Precautions are used to prevent each of these, but measures to minimize damage after the occurrence of an accident must also be provided.

Above all, it is important that all people in the university recognize the significance of cadaver dissection and the many risks associated with it, understand the mental and physical efforts made by the anatomy staff and the time spent by them, and provide mental and physical support to anatomy education. Without being cynical, I would say that the largest challenge for anatomists at present might be obtaining the understanding and cooperation of the university administration.

Concluding Remarks

Finally, I would like to add a few words about the body donation movement. Tokushi Kaibo Zenkoku Rengokai has been supported by cooperation from the national government, various associations in medicine and dentistry, local governments, and other organizations. At the general meeting held every year, speeches are given by the President of the Japanese Medical

Association and the President of the Medical Association in the area. Nihon Tokushi Kentai Kyokai receives a subsidy from the Japanese Medical Association every year. For 20 years, the Nippon Foundation provided an extraordinary sum of subsidy, as much as 100 million yen (870,000 US dollars) in total, but partly due to the financial condition of the Nippon Foundation, this grant was terminated ending with the payment in 2005. As a result, our PR materials that have been distributed free of charge now need to be purchased at cost.

The body donation movement and anatomy education are the foundation of the high level of ethics developed through medical education in

Japan. I sincerely ask all people in universities and medical institutions for their further understanding and support of the body donation movement and anatomy education.

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Simultaneous and Rapid Detection of Causative Pathogens in Community-acquired Pneumonia by Real-time PCR (1167)

JMAJ 51(1): 46–50, 2008

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Introduction

Community-acquired pneumonia (CAP) is still a major threat to individuals, especially children and compromised hosts such as senior citizens and people with underlying chronic diseases. The main causative pathogens in CAP are *Streptococcus pneumoniae*, *Haemophilus influenzae* and *Mycoplasma pneumoniae*, but the rates change according to age and the underlying disease.^{1,2} Recently, *Chlamydia pneumoniae* and *Legionella pneumophila* have frequently been identified as causative pathogens of CAP.^{3–5} In clinical practice, empirical chemotherapy with broad spectrum antibiotics must be started based on clinical symptoms, chest X-rays, and clinical examinations, considering the severity of the symptoms.

On the other hand, the increase of resistant strains in the CAP pathogens is a worldwide health problem.⁶ One effective measure to prevent the new emergence of resistant bacteria is to use only the sufficient quantity of the most appropriate antibiotics to eliminate target pathogens. We have developed a method to simultaneously identify the six pathogens in CAP by real-time PCR with high sensitivity and specificity, thus reducing analysis time and improving cost performance, toward the goal of the rapid and precise detection of causative agents.⁷

In this paper, I will describe an outline of the new identification system using real-time PCR assay for six CAP pathogens, *S. pneumoniae*, *H. influenzae*, *M. pneumoniae*, *C. pneumoniae*, *L. pneumophila*, and *Streptococcus pyogenes*.

Methods

Extraction of DNA from clinical samples

Samples of nasopharyngeal and sputum from pediatric and adult patients who were diagnosed with CAP at their first visit to a hospital, were collected after obtaining informed consent from patients themselves or from their family members.

Firstly, the samples were suspended in 1.5 ml of PPLO broth and centrifuged at 2,000×g for 5 min at 4°C to collect bacterial cells, together with epithelial and polymorphonuclear leukocyte cells. The supernatant was discarded, and the harvested pellet was resuspended in 150μl of DNase- and RNase-free H₂O. All DNA samples were extracted using EXTRAGEN II kit. The process of DNA extraction was completed in 20 minutes.

Identification of pathogens by real-time PCR

The six sets of bacterial specific primers and molecular beacon (MB) probes used in this real-time PCR have been reported by us.⁷ These primers and MB probes were designed on appropriate genes for each pathogen; the *lytA* gene was selected for *S. pneumoniae*, the *mip* and 16S rRNA genes for *L. pneumophila*, the *slo* and 16S rRNA genes for *S. pyogenes*, and the 16S rRNA gene for the other three pathogens were selected as a target, respectively.

As shown in Fig. 1, all of the MB probes were labeled with a fluorescent reporter, 6-carboxy-fluorescein (FAM) at the 5'-end, and labeled with a black hole quencher 1 (BHQ-1) at the 3'-end.

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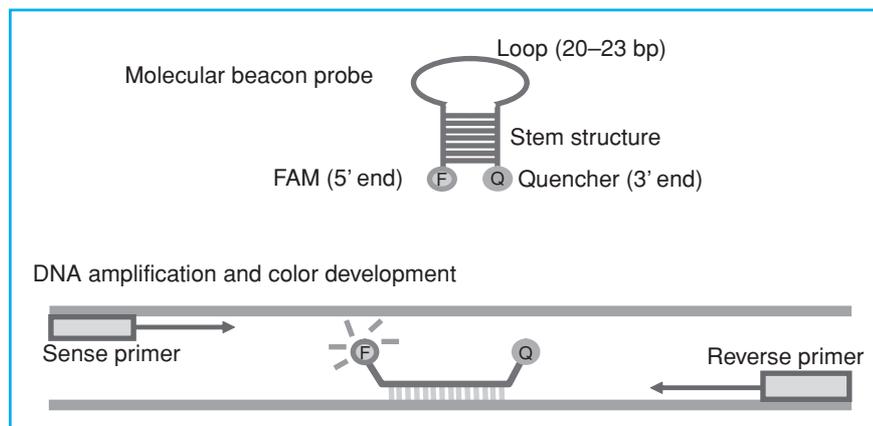


Fig. 1 Principle of real-time PCR using a molecular beacon probe

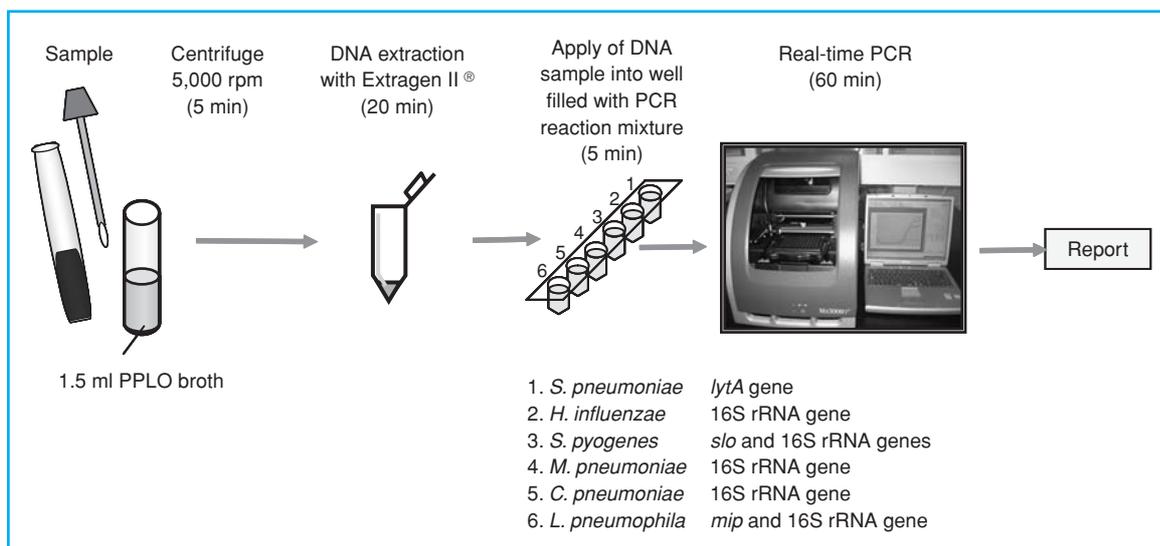


Fig. 2 Protocols of six pathogens detection from CAP samples by real-time PCR

The reporters and quenchers were connected to stem structure with short oligonucleotides. The central region of about 20 bp, which is shown as a loop, corresponds to the sequences of each target gene. The color development of FAM occurred by an attachment of the oligonucleotides to correspondent sequences of single stranded DNA at the denature stage.

The overall protocol of real-time PCR assay constructed by us is shown in Fig. 2. Reaction mixtures corresponding to six CAP pathogens were employed in six wells of one strip. After the addition of a 2 µl DNA extraction to the six wells, the strip was placed on the real-time PCR instru-

ment (Thermal cycler Dice, TP800, TAKARA BIO INC.), and DNA amplification was immediately started at 40 cycles of PCR with conditions at 95°C for 15 sec, at 50°C for 30 sec, and at 75°C for 30 sec per cycle, followed by 95°C for 30 sec. The results for every one cycle of the PCR were displayed on the screen of a personal computer connected to a PCR instrument. All processes in this protocol were completed in 1.5 hours.

Results

Sensitivity and specificity of real-time PCR

The Ct (threshold cycle) value for a positive

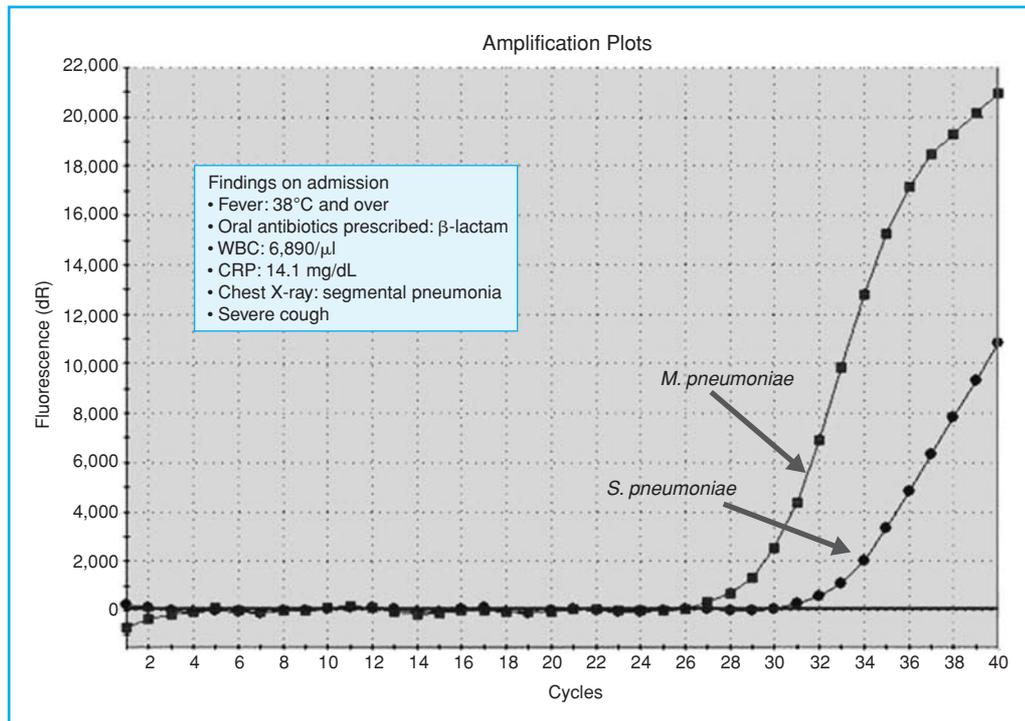


Fig. 3 PC screen after real-time PCR assay for sputum from adult patient with CAP

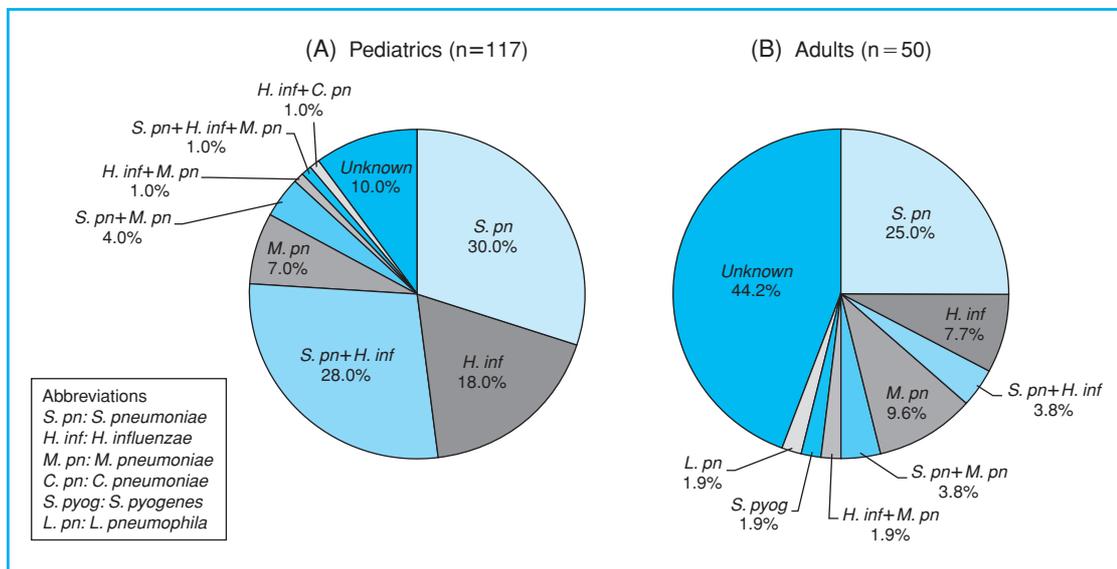


Fig. 4 Bacterial pathogens identified by real-time PCR in pediatric and adult patients with CAP

result was defined as the point at which the horizontal threshold line was crossed. The sensitivities of PCR assay for six CAP pathogens were high, from 2 copies for *S. pneumoniae* to 18

copies for *S. pyogenes* per reaction tube. The correlation coefficient between Ct and bacterial cell counts was high from $r = 0.9970$ of *S. pyogenes* to $r = 0.9992$ of *S. pneumoniae*.

The specificity of the six MB probe and primer sets were examined against 27 gram-positive and -negative microorganisms selected from laboratory stock cultures as amplification negative controls. From those organisms, no non-specific positive results were obtained.

Application of real-time PCR for clinical samples

Figure 3 shows the result of sputum collected from a typical CAP case in a young female adult. She was diagnosed with segmental pneumonia, having a severe cough, and hospitalized. The PCR results displayed on the PC screen suggested a mixed infection of *M. pneumoniae* and *S. pneumoniae*. Based on these results, medical treatment was conducted by combination chemotherapy.

Figure 4 shows the results of real-time PCR applied to pediatric patients (A) and adults (B) with CAP. The sensitivity and specificity of real-time PCR assay for *S. pneumoniae*, *H. influenzae*, *S. pyogenes*, and *M. pneumoniae* for 150 clinical samples was determined, comparing them with the results of conventional culture. Both the relative sensitivity and the specificity of this PCR was over 90% for all six pathogens.

Culture assay of *C. pneumoniae* has not been performed routinely in clinical laboratories, but has instead been determined by the antibody titer in acute phase and the convalescence phase. In all of *C. pneumoniae* cases identified serologically, the real-time PCR gave positive results.

Although the culture for sputum was negative, *L. pneumophila* pneumonia was identified by PCR in the case of an adult patient. Later, *L. pneumophila* serogroup 5 was actually detected in the water from the patient's bathroom.

Discussion

One of the measures to decrease healthcare costs and to improve benefit for patients with bacterial infection is to identify the causative pathogens rapidly and precisely, thus enabling the most appropriate antibiotic to be selected at the beginning of hospitalization. In the case of patients who were treated by antibiotics prior to hospitalization, the culture method may sometimes give false-negative results.

By real-time PCR molecular assay, it is possible to detect microorganisms with high sensitivity and specificity,⁸⁻¹⁰ even if bacteria have been damaged by the antibiotics pretreatment. Basically, the simultaneous detection of the main CAP pathogens described here is desirable for rapid diagnosis of CAP and for the selection of the appropriate antibiotics.

To determine causative pathogens, sputum has been employed in the case of adults. However, expectoration is impossible for infants and children. Alternatively, nasopharyngeal secretions are readily obtainable from children with respiratory tract infections (RTIs), but the test results must be analyzed carefully because healthy children also carry *S. pneumoniae* and *H. influenzae* in nasopharyngeal secretions.¹¹

Our data demonstrates that real-time PCR with pathogen-specific MB can detect microorganisms in a few hours, and thus by this assay it is possible to assess the time course of empirical chemotherapy, thus supporting infection management.

Finally, we also expect that the real-time PCR technique described here could be expanded into a multiplex real-time PCR to detect several RTI causative viruses as a general diagnostic method for lower RTIs in the near future.

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Working towards an “Open Medical Association”

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Under the Previous President Aburaya the Kyoto Medical Association has, in particular since 2002, conducted a range of activities with the slogan of An Open Medical Association. What this signified was releasing information widely to Association members to provoke discussion and promote the sharing of a stronger awareness of the various problems involved in healthcare, and also maintaining an attitude of keeping the public, both patients receiving care and their families, informed of and engaged in healthcare policy and the current state of healthcare.

Since April 2006 we have developed this policy further under President Mori and are working to bolster it. We report here on activities conducted recently and activities we are planning for the future.

Kyoto Healthcare Promotion Council

The Kyoto Healthcare Promotion Council was launched in October 2004 at the instigation of the Kyoto Medical Association and with the participation of 24 groups, including healthcare groups, patients' organizations and the Kyoto Federation of Senior Citizens' Club. As of April 2007, the Council's membership has reached 31 such groups. The Council periodically meets to discuss issues in such fields as the healthcare system, the system of healthcare provision and the system of nursing care provision, including specific examples from the field. The issues that occasionally emerge from these discussions have been raised at community meetings and featured in signature drives.

These community meetings include (1) “The Japanese Healthcare System Going Forward 2004:



The Future Course of Japanese Healthcare with the Ban Lifted on Mixed Medical Services,*³ with a presentation by rakugo performer Nanko Katsura and a panel discussion, in November 2004, (2) “Our Common Interest in the Future of Japanese Healthcare, Health Insurance and Welfare: From Child-rearing to Long-term Care,” with lectures and information booths, in June 2005, (3) “The Japanese Healthcare System Going Forward 2005: What We Can Do for You, What You Can Do for Your Loved Ones,” with dramatic sketches and a panel discussion featuring former Minister of Health, Labor and Welfare Chikara Sakaguchi, Asahi Shimbun journalist Hiroyuki Ota and Kyoto Medical Association Vice-President Katsutoshi Tachiiri, in December 2005, and (4) “Sea Change in Medicine, Health Insurance and Welfare: Your Health Crisis! Autumn Campaign,” with dramatic sketches, information booths, live broadcasting on KBS Kyoto Radio and interviews, in October 2006.

We also conducted two signature drives, gathering 79,632 signatures in October and November 2004 in the “Signature Drive to Save

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*3 “Mixed Medical Services” means that the services are paid partly by health insurance and partly by other sources.

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the Universal Medical Care Insurance System: In Opposition to Lifting the Ban on Mixed Medical Services” and 295,729 signatures in November and December 2005 in the “Citizens Movement to Save the Universal Medical Care Insurance System: A Rebuttal of Proposals for Structural Reform of the Healthcare System.” The 2004 experience in the first signature drive proved a positive advantage in the second signature drive in 2005, as the efforts of the members of the Kyoto Medical Association, who are the driving force behind Council campaigns, garnered over three times as many signatures as in the first outing.

A Circle Town of Rakugo Performer Tomaru Katsura “Everyone’s Health, Kyoto” Programming on KBS Kyoto Radio

As part of our efforts to bolster publicity activities under the new Mori leadership, in the first week of April 2007 we began providing 10-minute weekly spot programming for a regular Saturday radio program. We hope to use this 1-year opportunity to make the citizens of Kyoto aware of our misgivings and proposals concerning such areas as the medical associations, the healthcare system, long-term care insurance, healthcare and pharmaceuticals. We plan to include healthcare counseling and long-term care counseling features and to offer advice and exchanges of views on these issues in a way that local citizens can engage with.

Kyoto Medical Association “Medical Safety Symposium”

Medical safety measures will be a prominent aspect of restoring and enhancing trust in healthcare amidst the healthcare environment of recent years, and the provision of safe and high-quality healthcare is a pressing task for us now. In order to meet this challenge, the Kyoto Medical Association has established the Medical Safety Measures Committee, which has now held numerous discussions. Since 2003 it has held Medical Safety symposium and created opportunities for citizens and representatives of the healthcare professions to engage each other on the question of “Create a new environment for patient safety.”

One hundred fifty persons attended the first

symposium in February 2004 to hear such panelists as attorneys, representatives of citizens groups, and the Board Member of the Kyoto Medical Association, representing the medical profession, speak from their various standpoints on the central theme of “The Role of the Patient, the Role of the Physician: Create a new environment for patient safety” followed by a panel discussion.

Two hundred eighty persons attended the second symposium in February 2005 to hear panelists speak on the topic of “Create a new environment for patient safety 2005” followed by a panel discussion that included nursing and pharmacist representatives in a co-medical approach, with the hope of bringing patients and physicians together in a culture of medical safety. For its part, the Kyoto Medical Association advocated “Seven Must-do’s for All Physicians.”

Some 300 persons attended the third symposium in February 2006 to consider patient-doctor communications in the context of the theme, “The Patient’s Say, the Physician’s Say: In Promotion of Mutual Understanding.” Noting the great importance of medical safety of patient-doctor communication and informed consent, Professor Suguru Sato of the Literature Department of Doshisha University spoke from the perspective of psychology on “Communication on the Medical Front Lines: A Psychological Perspective.” This was followed by the presentation of dramatic sketches on the theme of communication and a panel discussion.

Two hundred sixty persons attended the fourth symposium in February 2007 to hear a panel discussion on “Patient-Doctor Communication: Informed Consent as the Bridge to Trust” among Yoshiko Tsujimoto representing the non-profit organization Consumer Organization for Medicine & Law, a member of the Kyoto Shimbun editorial board representing the mass media, and medical safety administrators and Medical Safety Measures Committee physicians representing the medical profession.

It is the objective of the Kyoto Medical Association to eliminate discord and misunderstanding in building relationships of collaboration, rather than confrontation, between patients and healthcare professionals and to build relationships of trust between the citizens of Kyoto and members of the Kyoto Medical Association, while promoting deeper understanding between them.

Infant Healthcare Activities of the Mie Medical Association

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Infant healthcare activities conducted by the Mie Medical Association consist of three programs: maternal and child healthcare, infant physical examinations and medical attention provided at kindergartens and daycare centers. As the infant examination program has the longest history of the three and is well-established as a Mie Medical Association process among our members, this paper will focus on this examination program while also outlining activities in the other two programs in recent years.

The Mie Medical Association Process in a Physical Examination Framework for Infants Aged 4 Months and 10 Months

Mie prefecture has long performed physical examinations, fully funded at public expense (costs borne at the municipal and village level) and performed on an individual basis, for infants aged 4 months and 10 months. The commission is set annually at an informal meeting of the Mie Medical Association, municipal and village representatives and the prefectural government, basically according to the criteria originally established when the national government declared it a grant program. The commission is set through this process, with attention to changes in medical fees made with revision of medical fee schedule and to needs of medical practitioners in the areas of obstetrics and pediatrics.

In order to improve the qualifications of examining physicians, we held physical examination workshops at five locations within Mie prefecture with the aims of attendants learning the Mie Medical Association process and gaining



knowledge of infant healthcare and made attendance a requirement for gaining qualification as an examining physician. During the 10 years since this practice began, the workshops were consolidated into one location several years ago with the objective of giving the workshop content fuller substance and the attendance obligation has itself been relaxed, but it is now mandatory for examining physicians to attend meetings of the infant physical examination committee in their local medical associations. (Absentees are required to submit a written case report.)

Fourteen city-level medical associations throughout Mie prefecture have established infant physical examination committees, which generally meet every month or every other month. They are deeply involved in regional infant healthcare through clinical conferences, follow-up guidance on children aged 1.5 years and through the review of the full scope of infant healthcare. The challenge we currently face is the provision of support to local committees where a dearth of leadership has resulted in inactivity.

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Overhaul of the “Maternal and Child Healthcare Guidebook (with antenatal consultation certificate and 4-month and 10-month infant consultation certificates)”

In 2006 the Mie Medical Association Infant Physical Examination Subcommittee (chaired by Hitoshi Ochiai, with Vice Chair Noriko Yamakawa) conducted studies of the adoption rate of the current examination checklist, comparing infant physical examinations at 18 months and at 3 1/2 years, in two model local areas and made revisions to the examination checklist in view of the changing objectives of these examinations. At the same time, the committee replaced the Yes/No question about anxiety over child-rearing with a new detailed questionnaire, the “Mother’s Interview Sheet,” to be filled out by mothers. In 2007 preparations are underway to implement these revisions through Mie prefecture.

Medical Attention Provided to Kindergartens and Daycare Centers

As part of preschool health activities, in 2005 the Mie Medical Association Preschool Medicine Subcommittee (formerly chaired by Takashi Kato, currently chaired by Machiko Isachi) drafted a Child Development Record Sheet (downloadable from the Mie Medical Association website at <http://www.mie.med.or.jp/hp/ishi/nyuyouji/kiroku/index.html>) for tracking children’s psychological development and early detection of strain in child-rearing, which is now employed in physical examinations. All parents and guardians are asked to fill out this sheet twice a year prior to physical examinations, and it is then used by physicians and children’s nurses and has come to be rather highly regarded on the ground. We now hope that it will also contribute to early assistance for children diagnosed with mild developmental disorders and assigned to special assistance education.

With a view to generating greater activity in preschool medical programs, in 2006 we began drafting the “Mie Prefecture Preschool Medical Programs Manual” and in 2007 plan to distribute it to preschool doctors, physicians and the relevant bodies involved in preschool medicine.

Further promotion of preschool healthcare programs will require a Mie Medical Association manual expressing an efficient activities policy. This will likely require no less than a forum for discussion, with medical association leadership, that includes all the relevant bodies involved, overcoming differences among the competent authorities.

Neonatal Auditory Screening Program

Currently over 50% of medical institutions that perform deliveries in Mie prefecture perform neonatal auditory screening. Although we designate medical institutions to perform complete examinations, much work remains to be done with respect to screening methodologies and provisions for children requiring examinations. In 2003 we launched a Neonatal Auditory Screening Commission (chaired by Masahiko Kubo) within the Mie Medical Association Maternal and Child Healthcare Committee and now aim to involve governmental authorities in promoting the program. At present, such operations as regular workshops, the collection and management of screening data, and governmental tieups (the government-led “Study Group on a Prefectural Framework for Early Treatment of Hearing-Impaired Children”) are only just underway, and there is much work to do in terms of, for example, the standardization of screening procedures, early treatment of hearing-impaired children and establishment of a framework for early support.

Prenatal Visitation Program

Prenatal visitation programs are currently underway in two areas in Mie prefecture (one of these as of 2005) and idle in one other area. At present, the chief concern is that whether the program will continue in these two areas must necessarily depend on whether strong leadership is in place.

In 2005 the Mie Perinatal Healthcare Guidance Programs Review Commission (chaired by Hitoshi Ochiai) was launched within the Mie Medical Association Maternal and Child Healthcare Committee as a subcommittee to promote prenatal visitation programs. The subcommittee membership is comprised of representatives of the Mie Medical Association, representatives of the obstetrics and gynecology

association, representatives of the pediatricians association and representatives from the prefectural government, and its activities are funded by the small fund that the first three thereof set aside annually to promote the program.

This remains a difficult undertaking, but we intend to draw on the Oita Medical Association procedures while working towards establishing our own Mie Medical Association procedures.

The Danish Society for Patient Safety— Operation Life Campaign

JMAJ 51(1): 56–57, 2008

Jens Winther JENSEN*¹

Introduction

For some years the Danish Society for Patient Safety has been very active in setting the agenda for the work on patient safety in Denmark. The Danish Society for Patient Safety is a private organization which was founded on the initiative of a group of people who after years in the hospital system realized that something drastic had to be done in the field of patient safety. The Danish Society for Patient Safety was founded in December 2001. The Board of the Danish Society for Patient Safety has a broad representation of the Danish Regions who are owners of the hospitals, the Danish municipalities who recently have been given a role to play in prevention of disease and rehabilitation of patients, health care professionals, pharmacists, the medical industry, research institutions and last but not least—the patients.

The Danish Medical Association currently holds the position of vice-chair to the Board which is chaired by the Danish Regions. To support the activities of the Danish Society for Patient Safety, the Board has engaged a secretariat with a staff of about 12 people. A large amount of funding for the activities is provided by a private insurance company and other funding is received through membership dues.

The assignment of the Danish Society for Patient Safety is to ensure that the issue of patient safety remains a top priority on the agenda of politicians, the Danish Regions and the hospital management and to gather and distribute information on patient safety. Furthermore the assignment is to instigate and participate in projects and work shops on patient safety and to develop

educational tools to enable health care personnel to deal with issues of patient safety in their daily work.

Reporting Unintended Occurrences

One of the main goals of the Danish Society for Patient Safety was to ensure that knowledge on mistakes and system failures are reported and used as a learning tool to improve patient safety and minimize harm to the patients.

In 2005 the Danish Parliament passed a law on reporting system failures and other unintended occurrences in the hospital sector. The reporting is currently done anonymously from the local level to the central level of administration and the law ensures, that health care personnel is not held accountable for the mistakes that they might have made in the treatment or the care of the patient. The principle of “no-blame” is introduced to ensure that by far most of the incidents are actually reported. The aim of the law is to categorize and develop guidelines in areas that have proven difficult for the health care personnel to manage. So far the work has resulted in guidelines from the National Board of Health in different areas such as administration of medicine, prevention of patients falling while in care of the hospital, prevention of burns subsequent to the use of alcohol for disinfection prior to operations etc. Equally important however are the local initiatives to follow up on the reported data and ensure changes in procedures locally where changes are indicated. A vast number of changes have been made locally since the reporting began.

At the moment the Danish Ministry of the Interior and Health is preparing to enlarge the scope of the law so that it will cover the primary

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care sector (General Practitioners and nursery homes) as well as the hospital sector. The new law is expected to be passed in the beginning of 2008 and is expected to be based on the same principles of “no-blame” reporting and follow up initiatives as the current legislation.

Operation Life

On 16 April 2007, the Danish Society for Patient Safety launched a campaign referred to as “Operation Life” (www.operationlife.dk). The target group of the campaign includes all Danish hospitals and the goal is to prevent deaths through the implementation of six interventions to improve patient care.

Background

In the United States, the renowned Institute for Healthcare Improvement (IHI) has successfully completed a national campaign known as “100k lives Campaign,” in which more than 3,000 participating hospitals, through the implementation of six evidence-based interventions, have estimated prevented deaths of 122,300 patients in 18 months. In the UK and Canada, similar campaigns are being instituted based on the same clinical interventions. Operation Life is inspired by both the British “Safer Patient Initiative” started by Health Foundation and the Canadian “Safer Healthcare Now!” carried out by Canadian Patient Safety Institute, but in particular IHI’s “100,000 Lives Campaign” has been a source of inspiration.

The six clinical interventions of the campaign

1. Rapid Response Teams to patients showing evidence of deterioration
2. Preventing adverse drug events by reconciling patient medications at every transition point in care
3. Preventing ventilator-associated pneumonia
4. Correct treatment of acute myocardial infarction
5. Preventing central line infections
6. Correct treatment of sepsis, blood infections

The interventions have been studied by an expert panel of Danish physicians and nurses and have been adjusted to comply with Danish guidelines and standards.

The campaign is open to hospitals that wish to join, and registration can be made at any time.

There are no restrictions as to the type and number of interventions the hospitals may choose to implement.

The goals of Operation Life

- prevent 3,000 deaths
- make sure that all regions are represented in the campaign from the start
- make sure that 75% of the patients in somatic hospitals are covered by the campaign once the campaign is closed.

Measures

Campaign results are measured in terms of number of prevented deaths and using an obligatory indicator for each intervention package. The goal of the campaign is to prevent deaths and this should be evidenced by monitoring the development (decline) in the national mortality rates at Danish hospitals in absolute figures. Mortality rates must be collected on a national and regional level. The mortality rates registered during the campaign period will be measured up against a hospital standardised mortality ratio.

Training programmes

Support is provided to the participants during the implementation phase, for instance in the form of “kick-off packages” (clinical guidelines, etc.) for each intervention, data collection and outcome follow-up, establishment of network and activities for sharing experience. Also a training programme using the “breakthrough method” is provided as support for implementation and quality improvement. The participating hospitals may appoint a number of teams consisting of 3–4 persons who are to undertake implementation at their own hospital, as well as training in the “breakthrough method” in a number of workshops. Instructor training in the breakthrough method is also provided.

Future Perspectives

The Danish Medical Association will work to improve patient safety and will therefore continue to support the activities of the Danish Society for Patient Safety to the benefit of the patients.

If you wish to learn more about the campaign in progress, please contact: Project manager Bodil Bjerg, tlf. 36 32 60 17, mail: bodil.bjerg@hvh.regionh.dk

New Zealand's World-leading No-fault Accident Compensation Scheme

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New Zealand is unique in a number of respects, and one which is of interest to the international medical community is our no-fault accident compensation legislation.

Prior to 1974, New Zealand had a regime similar to most other countries. Citizens who suffered the tort of injury caused by the action or negligence of some other person or company could sue for damages, and receive financial compensation for the injury. Amounts awarded in New Zealand never reached the dizzy heights seen in some places, but were assessed as compensation for pain, suffering, loss of function and loss of income. Employers were required to insure against injury to their employees; motor vehicle owners were required to carry third-party personal insurance (paid at time of vehicle registration), and public bodies and corporations generally insured against the possibility of damages awarded against them because of some injury traceable to their actions or inactions.

Some of the undesirable features of this tort-based workers compensation scheme included the propensity of some workers who had suffered an injury at sport or recreation at the weekend to limp along to work on Monday morning, and suffer an “accident” at work, and claim compensation for the injury. Another was the secondary gain from exaggerating the effects of compensatable injury.

The 1966 Royal Commission on Worker's Compensation, chaired by the Rt Hon Sir Owen Woodhouse, proposed what amounted to sweeping reforms. Its implementation was the 1972 Accident Compensation Act which came into force in 1974 and which, with some tinkering, has been with us ever since. Initially there was an Accident Compensation Commission, and the

scheme became universally known as “ACC.” The legal structure was later changed to a Corporation without disturbance of the acronym.

The Woodhouse Commission proposed five general principles:

- community responsibility;
- comprehensive entitlement;
- complete rehabilitation;
- real compensation;
- administrative efficiency.

Writing retrospectively in 1999 after 25 years of its operation, Sir Owen enlarged on some of the underlying rationale for the proposals that led to the ACC scheme. As he describes it, the pre-existing system of compensation was expensive in legal costs, slow in operation with many claims taking 5 years or more to be determined, and capricious in that similar injuries suffered under similar circumstances might produce vastly different financial outcomes. The outcome was a scheme that then seemed, and still does seem to many outsiders, radical. The right to sue for damages for the tort of negligence causing injury was removed, and in return injury would be compensated regardless of fault, including fault of the injured.

One of the early cases causing public outrage was the compensation of an inexpert safe-blower who misjudged the explosion and injured his hands. The acceptance of his claim was inevitable—consider the inequity that might result if those breaking the law were to be refused compensation: Suppose, for example, the case of a man driving the wrong way down a one-way street (and so in commission of an illegal act), and a workman on an adjacent high-rise building site dropping an untethered tool on his car and causing serious injury. He would be unable to sue, since that right

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was abolished by the ACC legislation, but by virtue of a relatively minor transgression, denied relief.

One of the most radical aspects of the proposal was that ACC would be principally funded by levies on employers, but injuries occurring outside the workplace would also be covered. Sir Owen explains this aspect of the scheme by showing that in the case of an employer carrying workman's insurance and paying premiums for that insurance, the cost of those premiums is loaded onto the products of the enterprise and therefore constitutes a tax on all of us. This was viewed as an aspect of community responsibility for injury at work that should then be extended to injury in other circumstances. The outcome was a proposal that the community should compensate for injury, regardless of the location and circumstances of the injury.

Writing in *Health Affairs* journal, Harkness Fellow Dr Marie Bismark and Health and Disability Commissioner Ron Paterson state that four main factors have contributed to the system's affordability. First, New Zealanders benefit from a strong social security system. Injured patients, like everyone else, receive free hospital care and subsidized pharmaceuticals. (Yet per capita health spending was only US\$1,886 in 2003, compared with US\$5,635 in the United States.) Thus, New Zealand's public health and welfare systems cover many of the damages that would be at issue in a U.S. medical malpractice claim, leaving the ACC with a much smaller compensation burden. Second, compensation awards are generally lower and more consistent than under a malpractice equivalent. Third, the New Zealand experience suggests that even under such a system (which includes a legal duty of open disclosure), most entitled patients never seek compensation, and many may be unaware that they have even suffered an adverse event. And finally, the New Zealand system does not incur large legal and administrative costs. The system has been very cost-effective, with administrative costs absorbing only 10% of the ACC's expenditures compared with 50–60% among malpractice systems in other countries.¹

Separate and independent processes are available for responding to patients' non-monetary interests (such as the desire for an apology, an explanation, or corrective action to prevent harm to future patients). In particular, the Health and

Disability Commissioner resolves complaints by advocacy, investigation, or mediation.²

One of the anomalies in the first 30 years of the scheme was its handling of complications and undesirable outcomes of medical treatment. If the provider of care were at fault, then this was an injury and was compensated. If it were a rare occurrence, for which the provider was not at fault (expected in fewer than 1% of cases) then it was a medical mishap, and compensated. If it did not meet either of these criteria, then it was not compensated. This always seemed anomalous in a no-fault scheme.

A review carried out in 2003 found that the requirement to establish fault impacted on health professionals by creating an overly blaming culture (rather than a culture of learning from mistakes) —by focusing too much on the actions of individual health professionals, and by making health professionals uneasy about participating in the medical misadventure claims process for fear of the repercussions, particularly from inter-agency reporting. The consequences of this included less focus on the patient's injury, less focus on the prevention of similar injuries, confusion over the Corporation's role, and opportunities to learn (and therefore improve) safety being limited.³

The New Zealand Medical Association (NZMA) had advocated for, and strongly supported, the amendment that came into force in April 2005 redefining all such occurrences as "treatment injury," and compensating regardless of perceived fault. That provides a much more equitable outcome for patients, and helps to avoid the adversarial situation that could previously arise where a patient was required to assert negligence on the part of the doctor in order to receive compensation.

There has, however, been some resiling from the original principles. The initial position was that the full costs of the accident would be met. The level of funding for care has been restricted, and most patients now find that they must make a co-payment for many items of assessment and treatment. There is a reasonable argument to make that this is not in keeping with the social contract inherent in the scheme, in that the right to gain compensation for costs has been removed and these costs should be met in full.

It remains an anomaly that in New Zealand accident, but not illness, is compensated. In the Woodhouse report, the principle of community

responsibility is stated thus:

Just as modern society benefits from productive work of its citizens, so should society accept responsibility for those willing to work but prevented from doing so by physical incapacity.

It is by no means clear why this should apply to accident but not to illness. There may be “contributory negligence” in both circumstances, and there is an inherent randomness in both circumstances. For example, ACC will pay compensation to someone who cannot work due to having organs damaged in a car crash, but the same level of compensation may not be available if they suffer organ damage through illness. This is a nettle that has apparently been too daunting for successive governments to grasp.

However, the deficiencies of New Zealand’s ACC system are small compared to its advantages (see Table 1). One of those will have been brought home to New Zealand doctors by the collapse in 2004 of the Australian medical indemnity system, brought down by huge claims and huge settlements. Because such claims cannot be made in New Zealand, our medical indemnity subscriptions are considerably lower than those of most comparable countries. This does not make New Zealand doctors more careless, although it may make us less risk-averse and more willing to deal with uncertainty of outcome. That is one of the strengths of our medical system—New Zealand doctors are still prepared to exercise clinical judgement, whereas it seems that our colleagues in some other jurisdictions have had much of that beaten out of them.

Table 1 Facts and statistics about Accident Compensation Commission (ACC)

According to the ACC, the scheme:

- provides cover for injuries, no matter who is at fault
- eliminates the slow, costly and wasteful process of using the courts for each injury
- reduces personal, physical and emotional suffering by providing timely care and rehabilitation that gets people back to work or independence as soon as possible
- minimises personal financial loss by paying weekly earnings compensation to injured people who are off work
- focuses on reducing the causes of these problems—the circumstances that lead to accidents at work, at home, on the road and elsewhere.

In 2005/2006 more than 1.2 million people had injuries treated by their local GP and paid for by ACC, with ACC paying for over 2.3 million visits. ACC funded NZ\$24.3 million in dental treatments and \$154.5 million in hospital treatments. ACC funded 2.6 million physiotherapist visits, 2.4 million visits to other treatment providers and 250,000 rehabilitation services. Rehabilitation rates are high: 66% of people return to work after 3 months, 84% after 6 months and 93% after a year. Injury prevention is a primary focus of ACC’s work, with campaigns focused on safety at work, at home, on the road and playing sports.

(Source: ACC website—www.acc.co.nz)

Acknowledgements

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The 25th CMAAO Congress in Pattaya, Thailand

The Confederation of Medical Associations in Asia and Oceania (CMAAO) congress was held with 50 participants from 13 national medical associations (NMAs) at the Hotel Royal Cliff Beach and Resort in Pattaya, Thailand, from 18 to 20 November, 2007. CMAAO is a confederation with a long tradition over nearly half a century and consists of 16 medical associations from various countries in the Asia and Oceania region—17 now that approval has been given for the Sri Lanka Medical Association to rejoin. These NMAs collaborate on specific issues, and each presents a report of its activities during the year at the annual meeting.

A general congress and mid-term council meeting are held every 2 years alternatively. The main theme of the symposium held during this year's congress was "Arts and Science of Healthy Longevity," which has become one of the main issues in healthcare in this region and reflects a global trend.

The congress venue was a luxurious hotel by the sea with several big convention halls for events and other facilities, as well as its own beach. The hotel was surrounded by lush greenery and tropical flowers which were frequently visited by birds. I discovered a couple of white squirrels playing in the forest near the hotel one morning. It was interesting to learn that people from different



Sunrise viewed from Royal Cliff Beach, Pattaya

NMAs also viewed white animals as a lucky omen, as we do in Japan.

The congress produced fruitful discussions. Agreement was also reached to make efforts to increase the number of participating NMAs. As the Secretary General of CMAAO, I would like to, with the JMA, facilitate closer communication between CMAAO members using the association website and journal. All the topics discussed at the congress will appear in this and next issue of the JMAJ.

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